The Journal

OF THE

AMERICAN ASSOCIATION
OF NURSE ANESTHETISTS

AUGUST 1945



VOLUME XIII

NUMBER THREE



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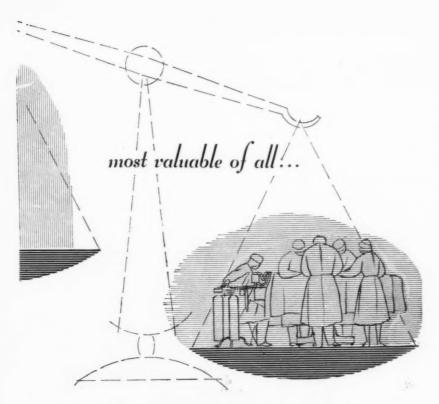
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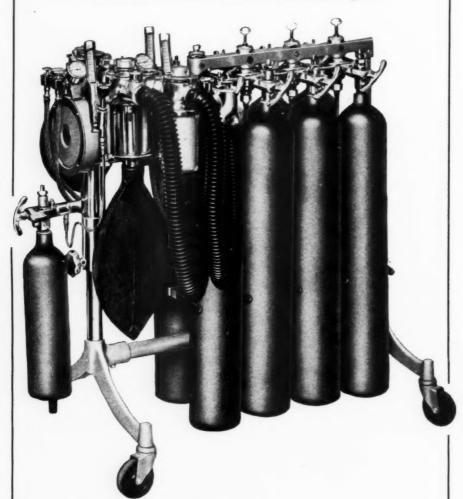


*Walton, R.P.: History of Anesthetic Drugs. J. South Carolina Med. Assoc. 40:60 (March) 1944.

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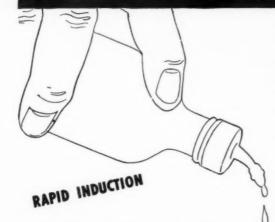
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The Journal of the AMERICAN ASSOCIATION of NURSE ANESTHETISTS

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Union Carbide and Carbon Corporation Inside back cover



This scene suggests a form of vicarious vacation . . . for just gazing at the tranquility of such a scenic view will have to suffice for many nurse anesthetists during these busy days when travel accommodations are at a premium and time is more elusive than money.

Pentothal Sodium Gaining in Favor

—A report on 1,350 cases prepared by SISTER M. BONOSA, M.S.C., Sacred Heart Hospital, Allentown, Pa.

Y FIRST EXPERIENCE with Pentothal Sodium was at St. Mary's Hospital, Athens, Georgia. I became familiar with its use, and had occasion to administer 200 anesthesias with the drug. Returning home I spoke about the great advantages of this anesthetic to our staff surgeons who had not as yet used it. One, however, had had experience with evipan in a European clinic many years ago. He initiated the introduction of pentothal sodium into our operating room and asked to have it administered to his patients for operations provided there were no contraindications to its use.

Slowly but surely, pentothal sodium became established in our operating room. At the present time almost all surgical procedures are performed under this anesthetic, with exception of nose and throat work and operations upon smaller children. Since its introduction into our operating room, August 1943, we have 1,350 pentothal sodium anesthesias on record.

Type of Operation:		N	0.	of	Cases:
Upper abdominal Lower abdominal, including	 				68
55 hysterectomies				T	56

 Cesarian sections
 14

 Resection of stomach or intestines
 9

 Appendectomies
 335

 Herniorrhaphies
 137

 Laporatomies, exploratory, etc.
 48

 Thyroidectomies
 13

 Genito-urinary
 60

 Gynecological
 148

 Rectal surgery
 60

 Operations upon the kidney
 18

 Eye Operations
 18

 Orthopedic surgery
 73

 Dental Surgery
 53

 Other types of operations
 140

From this outline it may be seen that we use pentothal sodium for almost all types of operations. Our equipment consists of an Adam's armboard, Rudder syringe holder, 50 cc. syringe, two-way stopcock, small piece of rubber tubing, glass needle adaptor, 20 gauge needle. Oxygen is used with pentothal sodium, either by nasal catheter or face mask, in all cases except the short ones lasting only a few minutes.

As premedication we use morphine and atropine and find that this combines well with the anesthetic. We avoid the use of scopolamine which depresses the respirations, and causes duskiness in color, and appears to be a predisposing cause of hiccoughs in combination with pentothal sodium anesthesia.

With pentothal sodium the first and second stages of anesthesia are not apparent. The third stage first plane may be reached within one minute. Nevertheless, the anesthesist who has had some experience with this drug will realize that adherence to detail is most essential during its administration. The patient is not conscious of a smothering sensation, as is often experienced with inhalation anesthesia, but dozes off as in a natural sleep.

Pentothal sodium should be administered slowly at all times. An airway is inserted as soon as the patient tolerates it and left in place until the patient reacts. This should be done cautiously to avoid stimulation of the cough reflexes. Hasty insertion of an airway might precipitate a laryngeal spasm which is more apt to occur with pentothal sodium than with ether because of the more complete muscular relaxation.

Another annoying and dangerous complication is vomiting. Care should be taken in questioning emergency and accident cases as to the time and consistency of their last meal. If there is food in the stomach the patient will vomit soon after the initial dose has been injected, and with the muscles of the throat already relaxed, foreign material will enter the trachea causing serious complications. Even with the most careful preparation a patient may vomit due to long retention of food in the stomach. At the first sign we immediately lower the head of the table and start the suction. A nasal catheter may be inserted and connected to the suction tube to remove all fluid from the naso-pharynx.

A minor complication is a slight cyanosis which develops soon after the initial dose is injected. This is immediately remedied by the administration of oxygen, which brings about good regular respirations and a normal color.

The third stage and the different planes of pentothal sodium are easy to control, as after relaxation is once obtained very little of the solution is necessary to keep the patient well relaxed. In abdominal sections it will be noticed with 2 or 3 cc. additional solution injected, the intestines retract in many cases almost equal to that of spinal anesthesia. Overdosage is prevented by watching the respirations, and signs are more correctly interpreted if gases are administered without manual pressure on the breathing bag. The pulse as well as the blood pressure remain normal unless influenced by the surgical procedure.

Occasionally a patient develops hiccough. This occurs more often in nervous individuals, and emergency cases where the premeditation has not had time to take effect. Hiccoughs are controlled by giving the patient carbon dioxide mixtures instead of plain oxygen. They are signs of light anesthesia, but if there is sufficient relaxation for the operation, the anesthesia should not be deepened.

Patients who have taken large doses of pentothal sodium are given 2 to 3 cc. of picrotoxin or metrazol intravenously before removing the needle from the vein.

Recovery from this anesthetic is usually without nausea and vomiting, a quiet awakening as from a natural sleep. A few patients may be restless and noisy, but only for a short while after which they will doze off again. If the respirations are too shallow or reaction delayed, the nurse on the floor makes use of the p.r.n. order for metrazol, which is given for all patients following pentothal anesthesia.

Pentothal sodium may be given to the

poor risk and mild cardiac patient. These especially are benefited by its use since they take so little of the drug that they are awake when taken back to the room. Postoperative nausea and vomiting, which cause dehydration and loss of strength and resistance, are absent. During the operation whole blood, plasma, or glucose in saline are easily administered through the same needle by adjusting the two-way stopcock. It is only with the robust and vigorous subjects that the above mentioned complications might arise with the administration of pentothal sodium. The weaker the patient is physically the more beneficial is its use as the anesthetic

Considering age limitation we do not use it for children routinely. Operations on children are usually of short duration, and since children tolerate ether very well we consider it the safest anesthetic for them provided there is no contraindication to its use. In the latter I would not hesitate to use pentothal sodium for a two year old child.

Following are cases of interest performed under pentothal sodium anesthesia:

Case 1: A white female, 51 years of age, was operated for carcinoma of the stomach. A one-third resection of the stomach was done followed by a posterior gastro-jejunostomy. The operation lasted 1 hour and 27 minutes and a total of 75 cc. of 21/2 per cent sodium pentothal solution was used. Nitrous oxide 75 per cent with oxygen 25 per cent was started after the induction and continued thruout the operation. Glucose in saline was given during the operation. The pulse remained between 96 and 108, color and respirations were normal. The patient was returned to bed in good condition and made a splendid recovery, leaving the hospital on the 16th day following the operation.

Case 2: A man, 62 years of age, on whom a palliative gastro-jejunostomy for inoperable carcinoma of the stomach was done, appeared to be in a comatose state, temperature 104 F. and the nurses became quite alarmed about his condition. However, the temperature dropped slowly on the second day, and he made an uneventful recovery.

Case 3: Though we have used pentothal sodium rather hesitatingly in cesarian section cases, we now find that it is perfectly safe to mother and baby to induce anesthesia with this drug. We do not use premedication for these patients and keep them as light as possible until the cord is clamped. We also have the suction ready for these operations in case of possible vomiting as retention of food in the stomach often occurs. Dilatation of the stomach should be a less frequent complication in these sections since there is no nausea and vomiting postoperatively.

Case 4: A white male, age 59 years, was operated for carcinoma of the descending colon. A two-stage Rankin operation was performed. Colostomy was done under pentothal sodium anesthesia, lasting 15 minutes, with 40 cc. of the drug being used. Two weeks later the patient returned to the operating room for the resection. He was placed in the face-down position for the dissecting of the rectum, then turned for the abdominal part of the operation, and at the end again placed in the face-down position for closure of the anal space. The operation lasted 1 hour and 15 minutes; 55 cc. of pentothal sodium solution was used together with inhalation of 50 per cent nitrous oxide oxygen mixture. The pulse remained between 94 and 110; glucose in saline was given

along with the anesthetic. The patient was returned to bed in good condition. The temperature stayed between 101 F. and 102 F. during the first week following the operation. Then gradually returned to normal. The patient left the hospital walking on the 14th day after the second operation.

Case 5: A white male, 53 years of age, with an enormous, irreductible inguinal hernia was operated under pentothal sodium anesthesia. Physical examination revealed the following: Respirations — dyspneic, shallow and moist. Lungs — scattered moist rales. Heart — enlarged 3 to 4 cm. outside midsternal line; sounds regular; blood pressure 150/125. Extremities — severe pitting edema of both legs and ankles.

The patient was of a very uncooperative type and the hernia too large to attempt the operation under local anesthesia. Sodium pentothal anesthesia was started very carefully. The color remained the same as before the operation - bluish lips and dusky skin, despite the use of pure oxygen. The pulse was satisfactory in volume, rate between 110 and 116. The operation lasted 55 minutes and 50 cc. of the anesthetic solution was used. The patient returned to bed talking and happy. The bed was adjusted to Fowler's position since the patient was used to sleeping in a chair. The patient had a moderate rise in temperature throughout his stay in the hospital but otherwise his recovery was uneventful. He left the hospital, walking, on the 32nd day after the operation.

We find pentothal sodium anesthesia most satisfactory for thyroidectomies, especially for the toxic patient. If the patient is not to know the day of the operation the anesthesia is started in the room, the patient is led to believe that she is getting glucose. Toxic goitre cases do well with small amounts of pentothal and the results are remarkably satisfactory.

Case 6: A man, 45 years of age, underwent an enucleation of the eye under pentothal anesthesia. To check bleeding the surgeon used small pieces of gauze dipped in adrenalin. Carefully watching the patient for any reaction it was noted that a few minutes later the pulse went up from 84 to 116, with no other reason for this than the application of the adrenalin. The blood pressure rose 30 mm. Hg. with pulse bounding returning to normal after some time.

Most eye operations are performed under local anesthesia; but for some, especially for enucleations, we use pentothal sodium. This drug, however, causes capillary oozing which is annoying to the surgeon during the operation, particularly in delicate work such as eye. The surgery eye specialist adds adrenalin to his local anesthetic solution to check bleeding. How far adrenalin affects the heart in pentothal anesthesia I do not know. From reports on fatal accidents with its use in combination with general inhalation anesthesia, in an attempt to check bleeding, we should use caution.

Case 7: A man, 24 years of age, with compound, multiple fractures of mandible and maxilla, was brought to the operating room for wiring of the jaws. Pentothal sodium was used as the anesthetic, oxygen fed by nasal catheter and suction used for removal of blood and foreign material with the pharynx well packed off with gauze. The operation lasted 2 hours and 15 minutes and 100 cc. of pentothal solution was required to keep the patient anesthetized. Pulse and color remained normal and the patient reacted one half hour after the completion of the operation. The patient

stayed at the hospital for several weeks, smaller adjustments had to be made several times, but finally left with an almost perfect jaw.

Conclusion: Pentothal sodium as an anesthetic is highly praised by patients and surgeons. However, there is no anesthetic which is one hundred per cent safe. When a new anesthetic is being used, it is watched for its effects during and after the operation, with a critical eye, and justly so, we must not attribute all undesirable things following the operation to the anesthetic alone. Ether has stood its test; we know complications follow its use; and try to remedy them. A patient who has had a spinal anesthetic introduced with perfect technique and success may complain of backache

following the operation, but the cause of this trouble may also be found in the complete muscular relaxation which is brought about by the spinal anesthetics. The same trouble may follow operations with other anesthetics which also cause complete muscular relaxation.

If we try to put signs and symptoms into their proper places we will find in pentothal sodium an anesthetic which is less harmful to the human body than many inhalation anesthetics. Although not all patients recover from an operation, yet many patients have a better chance with the use of pentothal sodium as the anesthetic; many patients recover sooner, and should they have to return to the hospital for another operation, they do so with less dread and fear.

Groups Forced to Change Convention Plans

Because of even graver transportation difficulties anticipated during the next several months, The American Hospital Association has cancelled its plans to hold a convention in Philadelphia between the dates of October 1 and October 5.

However, in order to properly carry on the essential business of the Association, it has been decided to tentatively plan on holding a meeting of the House of Delegates. This meeting is scheduled for November 5-6-7, Drake Hotel, Chicago. An announcement of the plans in the current journal of the American Hospital Association states: "This call for the House of Delegates is also a call for a general meeting of the Association and is as required in the By-Laws, but is issued subject to

cancellation by the Office of Defense Transportation. Attendance may of necessity be limited or the meeting cancelled by restrictions in effect at that date as ordered by the Office of Defense Transportation of the Federal Government."

Likewise the Tri-State Hospital Assembly has been forced to cancel its 1945 convention plans which originally called for a meeting on July 18-19-20, 1945. The 1946 dates, however, have been announced. These are May 1-2-3, 1946 at the Palmer House, Chicago.

The New York Nurse Anesthetists, which originally planned to hold its annual meeting June 11-12, has post-poned it until October 1-2, 1945, when it will be held at the Hotel Pennsylvania in New York City.

The Cardiac Patient Under Anesthesia

E. CHRISTINE COSTLEY, R.N., Mount Carmel Mercy Hospital, Detroit, Michigan

UR EQUIPMENT has been arranged, the case having been studied the previous night, and we sit down to begin the anesthetic on a patient with a cardiac condition. Fear may grip us and worries may fill our mind with what might follow the placing of the mask on the none-too-calm patient who has often heard the statement, "Cardiac patients always die on the operating table." The anesthetists have come to the realization that a decompensated heart is a very poor risk; whereas the compensated heart is a better risk depending upon the art and ability of the anesthetist and cooperation among the surgeon, internist, family physician, interne, anesthetist, and nurse.

Just as insurance companies accept heart cases only after increasing the premium, since patients usually succumb at a premature age, so does the surgeon feel that they constitute a real risk and the responsibility of anesthesia and surgery of these cases weigh heavily on his mind. It is of paramount importance in every case to determine whether surgical intervention is necessary or not. Surgery for hernias, appendicitis, cancer, diseases of the gall bladder, renal calculus, and ectopic pregnancies justify

operations on cardiac patients. Patients with congestive heart failure should be operated upon only in dire emergencies; in which cases, local or intravenous anesthesia is preferred.¹

The anesthetist's responsibility begins when the patient is scheduled for surgery. After careful preoperative care, including much rest, forced fluids if desired, and "building up" of the patient, he is brought to surgery.

After the anesthetist has studied the case thoroughly, one of the most important factors to be considered is the choice of anesthetic. The surgeon should be consulted as to the type preferred. Alertness is very important in giving anesthesia to cardiac patients. The anesthetist should be oblivious of all activity about her and devote every second of her time to the patient and to her procedure. She must have full control at all times of the depth of anesthesia and be prepared to meet any contingencies arising. She must recognize the symptoms of intolerance and changes in pulse (rate, volume, regularity, and force of beat), blood pressure, and in presence of heart disease, particularly, anoxemia must be avoided. The diseased heart has difficulty as it carries the needed oxygen to the tissues, and if anoxemia is marked or prolonged, it may result in acute heart failure and death.

Preparation for Surgery

Proper preparation is very essential except in real emergency cases such as

ruptured gall bladder, acute appendicitis, or an accident when bleeding must be controlled. Fatigue is a common complaint in both the healthy and unhealthy but plays a greater part in the case of a cardiac patient. Rest cannot be stressed too greatly, for the heart must not be overly taxed with duties of pumping the blood throughout the body when it must "stand up" under extensive surgical procedures.

Supportive measures must be used such as digitalis for digitalizing the heart. In some cases of heart disease it is necessary to restrict fluids. Vitamin B should be administered preoperatively in large quantities, for in the absence of this, one sees cardiac dilatation, tachycardia, and flattening of the T wave. Vitamin B2 is essential in the diet for the necessary supply of vital respiratory carriers. This view of Vitamin B deficiency shows rather clearly that an adequate preoperative vitamin diet becomes of great importance to the anesthetist particularly where the cell respiratory mechanisms are already under strain or restricted from lesions in the heart or other parenchymatous organs.

Every operative case during menopause which shows any cardiac symptoms or signs, or electrocardiographic findings suggestive of cardiac lesions should have the benefit of an adequate course of estrin substitution therapy.

Tests for the determination of heart efficiency have been devised by a number of surgeons. All cases over forty years of age, with a chronic disease, should especially have the benefits of these tests. Factors to efficiency tests are as follows:

- Blood pressure depends upon other factors than the heart itself.
- 2. Cardiac rate is increased often out of proportion to the pulse present.

- Increased cardiac work does not necessarily imply increased systolic output or increased blood pressure.
- The state of venous congestion in the splanchnic area may influence calculation.

The tests used may be any of the following:

1. Strange Breath Holding:

Technique is to have the patient breathe quietly for a few minutes. Then take one-half of a complete inspiration and hold it as long as possible. A patient with a good cardiac efficiency can hold the breath for 25 to 50 seconds, while under 20 seconds is considered poor. The chief objective in this test is the possible psychic factor, especially in nervous patients, and if there is a relative acidosis it is without value.

- 2. Vital capacity is taken by an instrument known as the spirometer. The patient sits or lies quietly for a short period of time and then takes a deep breath and exhales all possible into the machine. The measurement is in liters. The normal reading is dependent on the sex, weight and height. The lung capacity serves as an index to cardiac efficiency. It is interesting to note that the vital capacity is definitely decreased in most cases where the patient changes from the sitting to the prone position and is still more decreased in Trendelenburg position. Patients with decompensation may be compelled to sit erect or sometimes recline in order to breathe.
- The use of the electrocardiograph may be necessary to give an index to the efficiency of the heart muscle or the state of the coronary vessels.

- 4. An instrument known as the Cameron Heartometer, which determines the blood pressure by special neon and argon lights and also describes a graph of the brachial pulse, may add further valuable information.
- 5. A simple cardiac efficiency test may be to determine change in heart size. The stethescope is placed in the fourth interspace just outside the left sternal margin and a light percussion employed on the chest wall from the left toward the heart and from the right toward the heart. The sound comes forcibly into the ears when the border is reached. In this way the borders of the heart dullness and not the outline of the heart itself are determined as an index to the size of the heart. The patient's heart is examined in a prone position. Then the patient sits and lies down repeatedly for ten times. The heart then is re-examined. If any dilatation of the heart after this exercise is found, the heart will be leaning more toward the right side.

Effects on the Heart

A slow strong pulse indicates parasympathetic stimulation. A rapid strong pulse indicates sympathetic stimulation, which may be caused by hyperthyroidism or by operative stimulation without sufficient anesthesia of the sympathetic nerves. A rapid weak pulse indicates debility, anemia, hemorrhage or shock before operation, or collapse of the vasomotor and cardiac centers due to overstimulation by operative manipulation under insufficient anesthesia, or due to too deep anesthesia, too little oxygen, or a continued great excess of carbon dioxide. A slow weak or irregular pulse may occur as the terminal stage of the fast weak pulse or may occur primarily following an overdose of chloroform. An irregular pulse with rise in rate may be caused by overdose of anesthesia or insufficient amount of oxygen in blood and heart muscle.

Increased blood pressure indicates sympathetic stimulation. This may be caused by hyperthyroidism, operative stimulation without sufficient anesthesia of the sympathetic nerves, stimulation of the vasomotor center by moderate excess of carbon dioxide.

To the anesthetist it is especially important to know the action of the various drugs on the heart. Anesthetic drugs may be divided into two classes: namely, local and general anesthetics.

Ether, for over fifty years the most commonly used anesthetic, is irritating to the upper respiratory tract with reflex stimulation of the accelerator center and vasoconstrictor center in the brain, resulting in a faster heart beat and increased blood pressure. As the anesthesia passes the stage of irritation, the pulse and blood pressure fall somewhat but are maintained at a level above normal. Adriani states that the heart rate is normal, the cardiac output is increased with no effect on the muscle. There is an occasional varied arrhythmia and the cardio-inhibitory center is depressed. The blood sugar is increased 100 to 200 percent with a maximum rise in fifteen minutes with slight progressive rise thereafter.

Chloroform, for years given by the country physician in deliveries as well as by leading surgeons for operations, has, at last, reached the stage of discontinuation. It is a "poison to the heart"; its effect is that of weakening the action resulting in fatty degenera-

tion of the heart and other organs. It may, by vagus stimulation, cause a marked slowing of the heart, or it may, in turn, result in various arrhythmias which may be detrimental. The injurious effects on cardiac activity, potentially present in vago-vagal reflexes, are preventable or at least minimized, by atropine therapy. Adriani says the rate is variable; velocity of peripheral circulation decreased; cardiac output decreased 30 percent; ventricular fibrillation is possible, at onset; irritability is increased, and the muscle is depressed directly. The blood pressure falls, due to vaso-dilatation and action on the heart. The administration of adrenalin while the patient is under the influence of chloroform anesthesia may lead to ventricular fibrillation, and death of the patient may result.

Divinyl Oxide (Vinethene), although a relatively new anesthetic drug, has been proved by experiment to have no effect on blood pressure unless too deep anesthesia is produced, also a slight increase or decrease in pulse rate may result. However, it is to be used for only short procedures.

Ethyl Chloride primarily decreases the heart rate and then increases it. The cardiac output is decreased fifteen percent. Depression of the myocardium results and ventricular fibrillation may occur early due to increased irritability. Arrhythmias are enhanced by epinephrine. The blood pressure is decreased due to peripheral dilatation from the depressed vasomotor center.

Barbiturates in anesthetic doses lower blood pressure and increase the pulse rate, which, with the depression of respiration, are deleterious to a diseased heart. Another disadvantage is that once the drugs are injected into the vein, they cannot be removed. The myocardium is directly depressed by large doses.

Nitrous Oxide and Ethylene, both non-irritating drugs, produce anesthesia rapidly and with a less prolonged anesthesia post-operatively. There is less nausea and vomiting. In abdominal surgery it frequently is difficult to obtain complete muscular relaxation without increasing the depth of anesthesia to the threshold of danger, so that the supplemental use of ether is necessary. The state of anoxemia and asphyxia is harmful to a damaged heart muscle, which requires all the oxygen it can get. As the tissues and respiratory center becomes anoxemic, the heart attempts to compensate by sending more blood through the body by acceleration. This constitutes overwork and may result in further cardiac damage.

Cyclopropane, a drug which has the advantage over other anesthetic agents in that high oxygen may be given, is one which requires an alert and competent anesthetist for its administration. Complete relaxation is produced without the addition of ether. Cardiac irregularities may appear with very high cyclopropane concentrations and they are of reflex origin. Morphine has little effect on cyclopropane arrhythmias, but atropine, a vagal paralysis drug, seems to aid in preventing fibrillation. The clinical protection afforded by intravenous barbiturates may possibly be explained by depression of the hypothalamus. It is also possible that the barbiturates decrease the output of epinephrine by the suprarenal glands. There is much experimental evidence pointing to epinephrine as an important factor in the production of arrhythmias and to a close relationship between the hypothalmus and output of epinephrine. Thienes, Greeley, and Guedel state that high concentrations of cyclopropane do

not seem to be toxic to the heart, since extreme concentrations failed to produce changes in cardiac activity which one can interpret as muscle depression, except in the presence of anoxemia. High concentrations of cyclopropane (50 to 75 percent in alveolar air) or large doses of atropine abolish or minimize these arrhythmias in a large proportion of subjects. Reed says that the vago-vagal reflex disturbs cardiac activity which was more pronounced during light anesthesia, particularly during the introduction of intratracheal tubes, or inflation of cuffs. The derangement to cardiac activity is more pronounced under cyclopropane, and the explanation of this appears to be a potentiation of vagal activity by this agent. They are undoubtedly more easily elicited following morphine, avertin, and digitalis as have been shown in the case of the carotid sinus reflex. It is important to realize that the heart under anesthesia is functionally deranged; that is, a normal heart under anesthesia is as vulnerable to derangement from vagal stimulation as an originally diseased heart would be without anesthesia. The cardiac rate is decreased, cardiac output increased, and arrhythmias are common. A displaced pacemaker, vagus escape, a-v block, or ventrical tachycardia may occur at any time but more often with deep anesthesia. Irritability of the automatic tissue is enhanced further by epinephrine, which may result in ventricular fibrillation.

Avertin, although only a basal anesthetic drug, has very little action on the heart. The rate is increased, rhythm slightly changed, and large doses slow the heart because of dilatation. The blood pressure falls 20 percent or more due to vasometor depression and peripheral vasometor dilatation.

Spinal anesthesia produces a lack of sensation and muscular power depending upon the size of dose administered. The vessel tonicity in the area anesthetized is lost: as the dose is increased the intercostal muscles, big factors in respiration, fail and finally, if the dose has been large, the diaphragm, the all-important muscle of respiration, is paralyzed and the patient is in a critical condition. Expansion of chest aids in returning the blood from the body to the heart. With an impairment in this action there is more stasis of blood in the vessels in the affected area, which has already become dilated and toneless. This results in two conditions; one is lowering of the blood pressure, and the other is a decrease in the output of blood from the heart per minute. If a patient has hypertension, reduction in this pressure by spinal anesthesia will result in defective circulation through certain parts of the body with tissue damage because of anoxemia. If the action of the intercostals and diaphragm is impaired and the heart is already diseased, there will be placed upon it a greater load than upon a normal heart, since the minute volume output of a diseased heart is less than a normal one.

As a brief summary of anesthetic drugs and their action on the heart, chloroform and cyclopropane either may cause arrhythmias or ventricular fibrillation; therefore, these two drugs are unsafe to administer in inexperienced hands. Ether is a stimulant to the heart and is found to be a safe and satisfactory agent if administered properly. Its disadvantages are that of a relatively long action, post-operative nausea, and vomiting, and the long post-operative sleep. In 10,000 cases of ether administration, not one single death resulted from heart failure. Spinal anesthesia should not be

used in cases of hypertension. If a patient has a diseased heart from another cause, spinal anesthetic drugs should be used only in selected cases, where the dose administered is small, so that there is no interference with the return flow of blood to the heart by paralysis of the muscles of respiration. Broadly speaking, local anesthesia is preferred in cardiac patients on whom surgery must be undertaken. The second choice is ether anesthesia. Lundy states that ether is the best protective agent to the heart of all general anesthetics.

Complications Affecting the Heart

The normal mammalian heart has the property of originating within itself, without the aid of an external stimulus, the impulse which initiates each heart beat; in other words, the mammalian heart has a certain rhythmicity. When the myocardial fibers of the atria, instead of contracting simultaneously, enter into contraction in a haphazard fashion, the condition known as atrial or auricular fibrillation results. When the same situation exists in the ventricles, we are dealing with ventricular fibrillation. In short, ventricular fibrillation may be defined as an anarchic, disorderly and useless contraction of the ventricular fibers. As a result, no blood is expelled into the aorta and the arterial blood pressure abruptly falls to zero. The different organs of the body do not receive any blood and die, sooner or later, according to their individual requirement of oxygen and other nutrient materials.

Causes of ventricular fibrillation may be induced by an adequate electrical stimulus directly applied to either right or left ventricle. By "adequate" is meant a condenser discharge, a direct or alternating current of sufficient duration and strength, which, if short, must be applied at the proper moment of the heart cycle. It is evident that if the stimulus is applied on the skin, as in case of electrocution, instead of directly on the heart, the electrical stimulus has to be stronger to overcome the resistance of skin and body tissues.

Chloroform and cyclopropane, as previously mentioned, may lead to ventricular fibrillation in hearts which were previously normal. The administration of adrenalin during either of these anesthetics or the inhalation of benzol may produce this abnormal ventricular factor. A combination of cyclopropane and adrenalin may produce ventricular extrasystole, ventricular tachycardia, or ventricular fibrillation. Cyclopropane alone may cause cardiac arrhythmias which may develop into ventricular fibrillation.

Several drugs, in therapeutic doses, protect the ventricles against fibrillation but induce it at toxic dosage. Digitalis, ouabain, potassium chloride, procaine hydrochloride, quinidine sulfate and papaverine hydrocholoride, the last three of which protect the heart against ventricular fibrillation, may induce fibrillation in toxic doses.

The ligation of a coronary artery, an experiment which is duplicated in clinical cases of coronary thrombosis and coronary embolism, eventually produces ventricular fibrillation.

In the evolution of ventricular fibrillation, namely, as soon as ventricular fibrillation starts, the arterial blood pressure falls to zero. Ventricular fibrillation begins with an initial stage, very short, during which a coordinated contraction wave spreads rapidly and repeatedly over the ventricles; afterwards a stage of incoordination sets in, characterized by electrocardiographic deflections irregular in form and voltage; finally, after a

variable time, a few minutes to sometimes half an hour, all activity ceases in the ventricles. During ventricular fibrillation, the auricular rhythm remains undisturbed.

In the human being, once fibrillation has started the heart never returns to normal rhythm. A few cases of recovery from ventricular fibrillation have been reported, but it seems that a normal heart never reverts to normal rhythm in cases of true fibrillation, i.e. fibrillation beyond the first stage.

In 1933, Hooker, Kouwenhoven and Langworthy revived the method of stopping ventricular fibrillation by short runs of alternating current. Wiggers and Wegria modified the method and applied it to the dog's heart. Sometimes one such application brings the heart out of fibrillation, sometimes two to ten applications are required. The sooner the reviving heart shock is applied, the better the chances of stopping fibrillation. At the present time, revival from ventricular fibrillation has little practical application and is reserved to rather unusual cases, such as cases of electrocution and patients whose heart fibrillates during cardiac surgery. Therefore it seems that efforts should be directed toward prevention of ventricular fibrillation rather than cure.

All anesthetic agents and most alkaloids inhibit the enzymes, dehydrogenasas, which form such an important link in the chain of events which gives rise to the production of energy by the cell. This accounts, in part at least, for the hyperglycemia during anesthesia as well as decreased carbon dioxide build-up and various degrees of failure of cellular function.

Anoxemia may develop during anesthesia, especially during nitrous oxide and ethylene anesthesia. Changes in blood pressure must be observed for anoxemia. Cyanosis must not be tolerated, for it damages the brain and perhaps the myocardium.

Bradycardia, trachycardia, or arrhythmias may develop from action of the anesthetic drug or the patient's condition. Any rapid, thready pulse is a danger signal and the cause must be decided. It may be from anoxemia, hemorrhage, circulatory depression, shock, or numerous other conditions.

Pulse pressure variations are essential to report during any anesthetic, especially in brain surgery when it signifies intracranial pressure.

It is a generally accepted fact that the state of surgical shock is not due to heart disease and it is known that it occurs in individuals with normal hearts as well as in those with damaged hearts.

Loss of quantities of blood during surgery is another important occurrence. Sprague contends that patients with normal hearts are more apt to die suddenly under anesthesia than those with diseased hearts. Butler and his coworkers in Boston are of the opinion that in most types of heart disease the risk is not appreciably greater than it is in the normal person. Sudden deaths may occur under anesthesia with conditions of coronary thrombosis, congestive heart failure, and luetic aortitis.

Restoration of the Heart Beat

When the pumping action of the heart ceases and the arterial pressure disappears, the ventricles either come to a complete standstill or go into incoordinated fibrillary twitchings for a while before every vestige of movement disappears. Each of these means death unless a coordinated contraction is restored to the heart. In the vast majority of cases attemps at restoration are futile. A

myocardium poisoned by bacterial toxins or weakened by chronic disease cannot be made to function; but a patient whose heart stops suddenly in the operating room as a result of anesthesia, hemorrhage, respiratory paralysis, status lymphaticus, electrocution from cautery, vagus inhibition, pneumothorax, asphyxia or cardia trauma, sometimes can be saved.

The first requirements in restoration of the heart beat is aeration of the lungs. Success is impossible if the myocardium is cyanotic. Also the brain cannot tolerate anoxemia. Aeration of the lungs is carried out either by forcing air and oxygen into an intratracheal tube or by mechanical compression of the chest. Intratracheal insufflation is more effective and should be used whenever possible.

As a treatment of ventricular standstill, one cubic centimeter of 1 to 1,000 solution of epinephrine diluted with a few cubic centimeters of saline solution is injected into the left ventricle or cardiac muscle through the chest wall, at the same time massage being given to the heart. If the heart does not begin to pulsate almost immediately, the chest is opened and the heart is directly massaged forty to fifty times per minute. Aeration through an intratracheal tube should also be given. If the heart does not begin to beat, a similar quantity of epinephrine will be dripped on the surface of the heart or injected into the right ventricular cavity and massage is continued. Too much epinephrine will throw the ventricles into fibrillation. Manual massage should be continued because it can keep all the tissues viable and the beat can be restored if the muscle has not been irreparably damaged.

If the ventricles fibrillate, restoration of the coordinated beat is impossible

until the fibrillary movements disappear. This is accomplished by the use of procaine or metycaine on the heart. Two cubic centimeters of 5 percent solution of procaine or metycaine is dripped on the surface of the heart or injected into the right ventricular cavity. Massage is carried out continuously to maintain the circulation and to prevent dilatation of the heart. Success cannot be achieved if the heart is dilated. Two large electrodes are placed on the ventricles, and an alternating current of 1 to 1.5 amperes is sent through the heart for one-half to about two seconds. This sends all the fibers into contraction at the same time. and uniform relaxation follows. The heart is then at a standstill. Massage and epinephrine are used next. Too much epinphrine will send the ventricles into fibrillation, but it is difficult to cause fibrillation after procaine or metycaine has been used. It is needless to say that perfect aeration of the lungs is given throughout the entire procedure. The human heart was defibrillated for the first time on December 7, 1938.

The Anesthetic Risk

Surgeons undertake major operations upon cardiac patients with fear and trepidation. It is true that during such manipulations under anesthesia those various abnormalities in rhythm and rate of pulse may occur, but are largely those of transitory nature. When surgery is the only alternative after a complete diagnosis has been made, the cardiac patient is a good risk depending upon cooperation among surgeons, internist, and anesthetist.

Many factors determine the seriousness of heart disease, including the nature of the cardiac lesion, its extent, its tendency to progress, and the function of the heart. The age of the patient is always of great importance, as the most serious forms of heart disease to be considered in anesthesia is that occurring in old age. Because of the hardening of the arteries the heart muscle is more susceptible to any lowering of the oxygen content of the blood and cyanosis in the old is therefore more dangerous than in the young. Senile patients do not tolerate a deep anesthetic.

Patients with marked diminished cardiac and pulmonary reserve are naturally bad risks. The length of time that the heart disease has existed is of paramount importance to the anesthetist.

The heart disease of children and young adults is chiefly rheumatic carditis and congenital heart disease. Either type may exist and not materially increase the risk of anesthesia or operation, yet either may have resulted in such extensive damage and impairment of function as virtually to prohibit these procedures. Beyond adolescence all forms of heart disease are encountered, but outstanding are coronary disease, hypertensive heart disease, and syphilitic cardiovascular disease. Here again the problems are the same. The patient, regardless of the type of lesion, presents an individual problem and the most careful study and the most serious judgment must be exercised.

Patients during the stage of congestive heart failure should not be operated upon unless a dire emergency arises and when the procedure can be limited to a palliative one performed under simple, infiltrative anesthesia. When an operation seems to be inescapable, the patient who has a congestive heart failure, should, whenever possible, receive treatment until his condition has been sufficiently improved, if this is possible, to permit surgery to be undertaken with

reasonable safety.

Many patients with auricular fibrillation in whom the heart has not reverted to normal rhythm, have been operated upon without post-operative catastrophe. When fibrillation of moderate degree exists without dilatation to the right, the patient is considered a safe risk. The general behavior of the patient and whether or not the apex rate is rising too high just before the incision are other factors to be considered.

Toxic hyperthyroidism may have an effect on the heart. The anesthetic risk involved may be determined by testing the dilatation of the heart under nitrous oxide-oxygen only.

While the term acute cardiac dilatation as a fatal abnormality of the heart is generally accepted, many have questioned its occurrence. They cite the absence of necropsy proof; however, the post mortem might not have been done soon enough after death to determine its existence. In periods of apnea the heart may dilate to the right and blood pressure fall simultaneously. During hyperpnea, when there is relief from anoxemia of the apnea period, the heart returns to normal size and the blood pressure rises.

Hewlett states:

"Temporary moderate dilatation may aid muscular contraction but excessive dilatation lessens the contractile force of the muscle and changes that characterize acute cardiac dilatation supervene. The dilated ventricle fails to expel the blood coming to it. The venous pressure rises and this in turn tends to distend the ventricular cavity still further during diastole. If, however, demands are not reduced below the functional capacity of the weakened muscle the continuous collection of blood in the dilated ventricle leads

to cardiac death."

There must be constant observation of the pulse and prompt recognition of changes in the rate, volume, and regularity. Constant blood pressure readings must be recorded. In all events, in the presence of heart disease, anoxemia and anoxia must be avoided. Cyanosis is evidence of a marked anoxemia but it is important to recognize this condition prior to glaring manifestations. Anoxemia may be indicated by a rapid respiratory rate, rapid pulse rate with a diminished volume, and by marked irregularity or fall in blood pressure.

Just as the sugeon must work rapidly and not waste unnecessary seconds, it is just as essential that the anesthetist conserve time. Deep and prolonged anesthesia predispose to periods of anoxemia. Smoothness in giving an anesthetic is particularly important in heart disease. If a patient is forced to sleep, if the anesthetic is given too fast, a patient will struggle, vomit, and produce excessive bronchial secretions. These actions constitute a load upon the heart and with an existing state of poor compensation may be enough to produce a frank state of decompensation. The anesthetist should have a quick induction and smooth maintenance. If the condition of the anesthetized patient is changing from the preoperative condition to a state of degradation, it should be reported to the surgeon and he should be told to hasten his procedure. Again, if any unsatisfactory sign presents itself in a patient with a heart disease, it might behoove the anesthetist to remind the surgeon that the procedure must be terminated.

There is as much difference between a well administered anesthetic and a poorly administered anesthetic as there is in a night of restful sleep and one of restless sleep with nightmares and tossing about.

With the following available: an efficient surgeon; a good anesthetist who is alert and cognizant of the patient's condition; wise choice of anesthetic drugs; and only necessary surgery performed, the average patient with heart disease has a splendid chance of recovery.

Patients with heart disease are comparatively as good a risk as normal persons providing:

 That the heart is in a state of good compensation and that there is adequate cardiac reserve.

 That sufficient pre-operative treatment has been followed if necessary.

That the surgical procedure is not too long.

4. That the administration of the anesthetic is skillfully and adequately given, with as little distress to the patient as possible.

Dr. Oschner's words before the College of Physicians of Philadelphia in 1902 are:

"I think it would be unfortunate should surgeons receive the impression that patients suffering with heart disease are especially safe. I believe they are safe because they are considered unsafe."

It may justly be said that solving the problem of anesthesia in heart disease rests not so much in finding the ideal anesthetic but finding and developing the ideal anesthetist.

Summary

In the light of present medical knowledge, cardiac patients who must have surgery are not so frightening a risk as they were a number of years ago. With the development of local anesthesia, spinal anesthesia, intravenous anesthesia,

and cyclopropane anesthesia, cardiac patients have a much better chance of survival. With the improvement in medicine and surgery, anesthetic drugs, and methods of administering these drugs, we must also mention the importance of the nurse anesthetist who is well educated in giving any and all of these anesthetics.

Leading surgeons over all sections of the United States have time and again made the statement that they did not fear operating on patients who had cardiac disease with the following available: a good competent anesthetist, and a compensated heart.

Surgeons, family physicians, internists, internes, anesthetists, and nurses must be cooperative. Only with the complete harmony can the patient with a cardiac condition receive the best of medical care.

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Curare in Anesthesia

To MANY OF YOU: "The Flying Death" would sound like the title of a mystery story, but in reality it is Indian terminology for "Curare" which is now making a strong bid for recognition, especially in the field of anesthesiology.

Quickly scanning over the history of curare, we find that it is not a new discovery. For generations it was used by the Ecuadorian Indians as arrow poison. An infusion, concentrated to a thick syrup, was made of the bark and stems of plants. It meant almost instant death for its victims, the result of respiratory paralysis and asphyxia.

In 1938 Richard Gill returned to this country with a large amount of authentic curare. He spent many years among these natives learning the secret of its extraction. Botanical specimens of over forty plants were used in making various kinds of crude curare. In this country, the chemical and botanical development of curare was due largely to the efforts of the Squibb Laboratories and to Dr. McIntyre, Professor of Pharmacology at the University of Nebraska. Now that element of cardiac and respiratory depression has been removed and

there remains only the pure curare effect, that is, the interruption of the nerve impulses at the neuro-muscular junction.

This purified drug has been commercially labled "Intocostrin" by Squibb and it was first used in connection with shock therapy to soften the shock and prevent traumatic effects, in the treatment of tetany and chorea, as well as for the control of muscle spasm in spastic disorders. It was in 1942 that Dr. Harrold Griffith of the Homopathic Hospital of Montreal, began to use it in surgery, and published the results of its successful administration in 25 cases.

Just how, you might ask, does this curare interest me as an anesthetist? Let us consider the two-fold interest we have when administering anesthetic agents. Primarily, regard for the patient; secondarily, regard for the surgeon. A patient submitting to an anesthetic literally places his life in our hands, and we thus assume a grave responsibility. We are concerned not only with the safety and welfare of the patient during narcosis, but also during convalescence, and with preventing, as far as is possible, undesirable sequelae. From the surgeon's standpoint, it is up to us to provide sufficient relaxation for him to work quickly and smoothly. With this in mind then, let us take a few of the anesthetic agents at hand and consider

Read at the meeting of Michigan State Association of Nurse Anesthetists, February 17, 1945, at St. Joseph's Mercy Hospital, Detroit. their inadequacies in intra-abdominal surgery.

Ether, probably the most popular and essential of all agents used today, is capable of producing extreme muscular relaxation, but due to the increased diaphragmatic movements, the intestines will not contract. Prolonged ether anesthesia predisposes to a post-anesthetic recovery period of nausea, vomiting and sometimes abdominal distention. We know, too, that acidosis and the possibilities of respiratory complications increase the hazard of ether anesthesia. Relaxation in abdominal surgery cannot be obtained with nitrous oxide unless combined with ether. Ethylene and cyclopropane, both capable of producing a quiet abdomen, are not sufficient in themselves to produce optimal relaxation unless pushed to near lethal dosage or by apnea technique, which predisposes to trauma, even in the most experienced hands.

Frequently, under most favorable conditions, occasions do arise when it is impossible to get a patient sufficiently relaxed to satisfy the surgeon. This is where curare is of extreme interest and importance to us for it is able to produce that optimal state of relaxation quickly and harmlessly in combination with an agent. It is not an anesthetic in itself, but when it is combined with an agent, the amount of the anesthetic and the depth of narcosis is decreased, and post-operative complications which sometimes follows deep, prolonged anesthesia are avoided.

Dr. Griffith (1) in his preliminary report on the use of curare in general anesthesia, describes the following technique: Intocostrin is administered intravenously with a dosage of 10-20 mg. of the active curare per 20 lbs. of body weight, 1 c.c. of Intocostrin contains 20mg. of the active curare substance, so

that the average dose for the adult patient is 4-5 c.c. He made the injection rather rapidly and reported no cases of thrombosis or other local reaction. His theory was that it should be used only to overcome some critical situation and subsequent muscular relaxation should be maintained by the use of the anesthetic agent itself.

Dr. Stuart C. Cullen, of the University of Iowa, has published reports on the use of curare in anesthesia (2) in 131 surgical cases in 1943. Of this number, four patients under ether anesthesia were given curare. Two of these suffered no significant respiratory depression from moderate amounts of the drug, but the other two suffered prolonged and pronounced respiratory depression. At first it was believed that curare was contra-indicated in ether anesthesia, but subsequent studies have revealed that it may be successfully used during ether anesthesia by reducing the dose to 1/3 of the amount ordinarily given during cyclopropane anesthesia. Cyclopropane has been the agent of choice most widely supplemented with curare for the hazard of cardiac complication is reduced because it is no longer necessary to use high concentrations to obtain the desired relaxation.

In September of 1944, we began using curare at St. Mary's Hospital. At first we employed it cautiously and, according to the suggestions of the aforementioned men, only upon selected cases in combination with cyclopropane. Our earliest cases were those for which profound relaxation was desired, such as, gastric resections, gallbladder operations and repair of ruptured ulcers. Finding it entirely satisfactory, we began using it for emergency operations upon patients whose general condition would permit only a minimal amount of

anesthetic agent. Close observation of these primary cases, led us to adopt the rather modified technique now followed in most of our intra-abdominal operations. The usual pre-operative medication of morphine and atropine or morphine and scopolamine is given. The patient is brought to the operating room and intravenous fluids of glucose in saline or glucose in distilled water is started.

The patient is then anesthetized in the usual manner to the first plane level of the third stage and maintained there, using cyclopropane or ethylene. 3 cc of curare are introduced intravenously just before the peritoneum is opened and with this the flow of the anesthetic agent is discontinued for a few moments until the degree of respiratory depression is determined. Usually, in 30-40 seconds the marked change in the respiratory rate is noted; respirations become quiet and shallow (if jerkiness occurs the oxygen is increased and a moderate pressure applied to the rebreathing bag will reestablish regularity in from 2-3 minutes). At this point the peak of curarization is reached, and the peritoneum opened reveals a flaccid, contracted intestine. This state can usually be maintained until closure of the abdomen with a minimum amount of the anesthetic agent. If the operation lasts longer than 45 minutes, it is sometimes necessary to give an additional 2 cc of intocostrin just before the peritoneum is closed.

With curare in abdominal surgery, we prefer to use cyclopropane and oxygen, and no ether is required; if ethylene is used, a very small amount of ether may be added, particularly if the patient is robust and the operation prolonged. In our series of cases, only one incident of marked respiratory depression has

occured. This patient had been under nitrous-oxygen-ether anesthesia for removal of a gallbladder, when some difficulty in obtaining sufficient relaxation was encountered. 2 cc of intocostrin was given and voluntary respiration ceased. The lungs were inflated with oxygen and 1 cc of prostigmine was administered intramuscularly. The pulse remained good, the airway was patent and the respiration was maintained with artificial ventilation by manual compression of the re-breathing bag. In 5 minutes voluntary respirations were resumed and for the remaining 25 minutes of surgery the patient was carried on nitrous oxide and oxygen. Closure was accomplished with ease and the patient left the operating room in good condition. Convalescence was uneventful

We have also found curare invaluable in simpler cases where ether is contraindicated, and its use with intravenous anesthesia has recently been adopted. The combination of curare with pentothal sodium is considered by some authorities as unnecessary because of the excellent relaxation provided by the pentothal itself, although others are using it in various types of cases. At present, we are using it for rectal work. One of our proctologists for many years has done most of his work under 50mg. of spinal with excellent results, but the occasional patient presenting a problem by objection to being awake during the operation or fear of the spinal puncture, led us to use pentothal sodium. The profound relaxation to which he was accustomed, could not be obtained unless rather large doses of the barbiturate were given, so curare was used to supplement the barbiturate.

The average patient is pre-medicated with morphine 1/6 and atropine 1/150

one hour before surgery. After the patient is placed in the lithotomy position, the intravenous anesthetic is administered in the usual manner; upon loss of consciousness, the patient is surgically prepared and just before the surgeon is ready to begin his work, 2 cc of curare are injected intravenously. A marked relaxation of the rectus muscle is noted within 30-40 seconds and he finds it comparable to that of spinal anesthesia. Continuous nasal oxygen is given throughout the operation and no instances of respiratory depression or other untoward effects have been noted. Patients are given ½ cc of pictrotoxin intravenously before they are taken from the operating room and are usually awake or reacting upon return to their room. The amount of pentothal used has varied from 20 to 35 cc, of a 21/2

per cent solution.

Since surgeons are becoming more and more aware of the benefits derived from the use of curare to induce muscular relaxation during intra-abdominal surgery, many of you may be called upon, in the not-too-distant future, to use it. You are reminded to proceed cautiously with the drug and familiarize yourself completely with it before attempting its use. Success with curare so far has assured it a place in anesthesia in surgery, but further studies are in progress and what new possibilities of the drug they will uncover, remains to be learned.

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Members, please note!

In returning statements of dues individual members are responsible for indicating correct address. It is suggested that the name be printed in one place, for legibility, address should also be printed. It is helpful if abbreviations are not used. Street, Avenue, etcetera should be indicated and, if your city is zoned, the zone number included in your address.

In sending changes of address we suggest you use the following form.

Former address		
Name		
Street		
City	Zone	State
New address Name		
Street		
City	Zone	State
Indicate by check mark	if your membership is to l	be transferred or, if
address is temporary	for how long	? Changes of
	promptly to the Executive	

LETTERS from Members

HILDA ELIASON writes from the Pacific Theatre, "We are 'swamped' with work besides fighting the old tropical sun by day and the hungry mosquitoes by night. Our anesthesia department carries a load four times too great for normal functioning, but some day it will all be over and we may return home and enjoy a rest."

GENE FINNEY writes from Mexico, where her husband is located in connection with a steel mill. She and her family are in a poor section of Mexico, where life in no way compares with life in the United States. She says:

"All milk must be boiled and drinking water transported from a neighboring town where there is a spring. There is no refrigeration so you can imagine the meat situation and, since we have been here, we have seen no sign of butter. Living costs are as much here, and for some things, more than in the states. Most of the natives are very poor but it is surprising how happy and pleasant they are. The large majority of them are quite friendly.

"During this adjustment period I have had no idle time. There is no American school so I have spent time with my oldest boy on his studies. In the Spanish schools there are no sanitary facilities (which sounds almost unbelievable) so I have not started him in school, for fear of illness...

"We are quite cut off from things

down here. Our radio has 'salpingitis' and there are no radio tubes available. Some few people have radios, but due to the poor electric current, they are unable to get reception. Our newspapers arrive about two weeks late and mail is quite slow. Airmail saves little time. We have electric lights, which are comparable to candle light, from dark till eleven P.M. Blackouts are taken for granted, for the gasoline engines used to generate electricity frequently break down. Kerosene (petroleum, they call it) is used mainly for lights and cooking. It is quite interesting, or perhaps I am making an effort to think so. The romantic and beautiful Mexico we think of did not originate in Monclava."

Journal "Deadline" Dates

Material contributed for the November issue of The Journal of the American Association of Nurse Anesthetists should conform to the following schedule of due dates:

Professional articles: September 15. News reports, association minutes, miscellaneous items: October 1.

Advertising copy and space instructions: October 1.

Because of production routines and other requirements these "deadline" dates must necessarily be strictly adhered to. Readers are urged to keep them in mind.

ABSTRACTS

It is the aim of this department to bring before readers recent publications which we believe are of practical value to the nurse anesthetist. We shall also call to your attention articles not so recently published that are of lasting interest. Some articles will be merely listed; others will be abstracted. Wherever practical abstracting will be done by the use of direct quotations. Contributions and suggestions will be most welcome.

AUTHOR:

JOHN ADRIANI, M.D. The Effect of Varying the Moisture Content of Soda Lime upon the Efficiency of Carbon Dioxide Absorption

PUBLICATION:

Anesthesiology, March 1945

Volume 6, Number 2

"In army installations certain drugs are 'standard' for inhalation anesthesia . . . The factors influencing the choice of nitrous oxide as the Army's only gaseous anesthetic are not known, but certain advantages of nitrous oxide are well established . . . The safety of nitrous oxide for minor operations is well established by millions of administrations during the century that it has been in use. . . . Surely if nitrous oxide were as unsafe as its detractors would have us believe its use would have been abandoned years ago. . . .

"The principal disadvantage of nitrous oxide is its lack of potency. . . . In military surgery the great majority of patients are young robust males, in the pink of condition, usually addicted to tobacco, and often to alcohol. Such subjects are resistant to any anesthetic

agent, particularly to nitrous oxide. On the other hand, ninety-four per cent of the operations at this installation are extra-abdominal, and less muscular relaxation is required. Such operations are well within the scope of nitrous oxide.

"Adequate premedication is an important part of the administration of nitrous oxide, for it is believed that the lowered metabolic activity induced by narcotic drugs will result in a lessened demand for oxygen, thus permitting an increase in the percentage of nitrous oxide in the mixture without reducing the oxygen to an hypoxic level. If it is decided to use nitrous oxide, pentobarbital (nembutal) gr. 1½ (97 mg.) is given at bedtime, and repeated at six in the morning. One hour before operation morphine gr. 1/4 (16mg.) and scopolmaine gr. 1/150 (.4 mg.) is given hypodermically. Appropriate variations in these doses are made for persons with malnutrition, anemia, toxemia, or other abnormalities.

"If the patient, on arrival in the operating room shows evidence of poor narcotic effect, is unduly apprehensive, or is exceptionally robust, basal anesthesia is induced with sodium pentothal. . . . In most cases no additional pentothal is necessary; the basal dose is completely metabolized during the anesthetic period, and the recovery is comparable to that following nitrous oxide anesthesia. If the operation is prolonged, if more muscular relaxation is desired or if good anesthesia cannot be maintained without the development of symptoms of hypoxia, additional 21/2 per cent pentothal solution is added during the anesthesia...

"In certain situations where an arm board would inconvenience the surgeon, . . . the following technique is used: Two grams of 21/2 per cent pentothal solution is prepared. Basal anesthesia is induced as has been described. This usually required less than 500 mg. The remaining pentothal solution is injected into a standard 1000 cc vacoliter bottle of physiological saline through the needle which acts as the air inlet. . . . A needle is introduced into an ankle vein, and this weak pentothal solution is allowed to flow continuously through the usual intravenous setup. A rate of one drop a second will give the patient about 500 cc (0.7 gm.) per hour, and in most cases this will be sufficient to maintain the original basal anesthesia. . . .

"The depth of anesthesia may be varied by adjustments in the concentration of either pentothal or nitrous oxide, or both. However, it seems preferable to maintain the pentothal at a minimum basal level and vary the nitrous oxide according to the patient's needs. . . . It is contrary to Army policy to use sodium pentothal as the principal agent in prolonged or major operations, in morphine overdosage, in shock, and in liver damage. It is considered especially dangerous in infections of the neck, as it is felt that inflammation in the region of the carotid bodies causes sensitization of reflexes arising there, and adds further respiratory inhibition to the depression of the respiratory center induced by pentothal. Unsupplemented pentothal is considered hazardous in the presence of obstructed respiration, in positions involving respiratory embarrassment, or in operations on the air passages. The use of pentothal is contraindicated in intracranial operations or in patients with severe burns."

Author: Major Kenneth G. McCarthy, Louisville,

Ky.

TITLE: Nitrous Oxide in

Army Hospitals

Publication: Current Researches in

Anesthesia and Analgesia — March - April

1945

"For a number of years, two types of soda lime have been available for carbon dioxide absorption for clinical anesthesia, a 'high moisture' and a 'low moisture'. The high moisture usually contains approximately 15 per cent by weight added water, and the low moisture less than 2 per cent. Frequently, the question is asked as to which type is the more desirable for rebreathing appliances for anesthesia. . . . Since data regarding the efficiency of each type of absorbent, as far as anesthesia is concerned, are scant, it was decided to investigate this aspect of carbon dioxide absorption in more detail. . . .

"Soda lime for inhalation anesthesia is a mixture of sodium hydroxide, approximately 5 per cent, calcium hydroxide and water. The bulk of the mass is calcium hydroxide. The absorbent is prepared in the form of various sized granules. The optimum size for most of the currently employed rebreathing units appears to be 4-8 mesh. The end products of absorption are sodium carbonate, calcium carbonate and water. The most efficient absorption occurs when the tidal volume of the subject equals the combined intergranular and intragranular air space in the charged canister. A cylindrical canister 8 by 13 cm. usually contains 500 to 550 Gm. Such a charge will absorb effectively for a period of time under sustained use when it suddenly appears to become exhausted. The exhaustion, however, is

only apparent because if the charge is allowed to rest for several hours, a regeneration of activity occurs. That is, if one charge is used again, absorption proceeds almost as efficiently as before, but for a shorter interval. Ultimately, when the entire mass is converted to carbonates, absorption ceases and the charge must be rejected. The periods of absorption efficiency are of shorter duration and more frequent in the circle filter than in the to-and-fro when identical conditions exist. Absorption occurs on the surface of the granule. The conversion of hydroxides to carbonates occurs from the surface toward the heart of the granule.

"Specimens of 4-8 mesh soda lime containing 0.5, 9.6, 15.2 and 22 per cent by weight added moisture were specially prepared for this study. . . . Each particular phase of study was done in triplicate for each type of absorbent. . . .

"Specimens of soda lime containing 0.5 per cent, 9.6 per cent, 15.2 per cent and 22 per cent moisture were tested in the laboratory and clinically for their carbon dioxide absorption efficiency. The following results have been obtained: In the to-and-fro filter, all specimens were effective absorbents under conditions usually encountered clinically. The variations between the different specimens are slight and of no apparent clinical significance. In the circle filter, the absorption efficiency improved as the water content of the absorbent increased. The high moisture content absorbents are more effective in this type of unit. Specimens containing 22 per cent of water became wet as absorption proceeded and were not desirable. The optimum water content from the standpoint of efficient absorption and ease in handling of soda lime should be somewhere between 10 and 22 per cent."

Author: N. A. Gillespie, Madison, Wisconsin

TITLE: Death During Anes-

thesia.

Publication: Current Researches in

Anesthesia and Analgesia, November - December 1944.

"The 'safety' of anesthesia is a recurrent and fertile subject of argument. Unfortunately any discussion of safety has usually turned on the anesthetic agent in use instead of on the skill and experience of the administrator of that agent, or on the condition of the patient. . . . The laudable habit of keeping records accurately in writing is still so new among anesthetists that to them 'mortality' usually means the number of patients who died on the operating table. ... There will be no real advance until surgeon and anesthetist are sufficiently 'members one of another' that each feels deeply for the other's troubles. As the principal members of the team they must learn to act jointly, not severally. ... The 'gross mortality' of surgical interventions is the number of patients who did not survive to be discharged from hospital or to be operated upon again. . . . By 'immediate mortality' the anesthetist should mean the number of patients who died before recovery of consciousness after anesthesia. It is obvious that the immediate mortality of operations depends mainly on the nature of the operation and the condition of the patient before it. . . . Specialized institutions will provide an unfair picture in one or other direction. . . .

"Immediate Mortality. — 'A death on the table' is the bugbear of the anesthetist. It need not necessarily be his fault. Many surgical causes may be responsible. Hemorrhage, or a decrease in effective circulation resulting from trauma are the usual precipitating causes. If a sufficient number of operations are performed upon patients in poor condition, sooner or later one of the fatal accidents will occur during operation. . . . The serious accidents of anesthesia are usually sudden and often fatal. Our knowledge and mechanical aptitude have reached a point at which the function of respiration, vital as it is, is under the control of a skilled anesthetist. A few years ago cessation of voluntary respiration in an anesthetized patient was a sign of grave import. Nowadays, in certain circumstances, it is viewed with equanimity, and a skilled anesthetist often produces apnea deliberately for certain purposes. In the broadest sense the modern anesthetist has 'taken control of respiration.' The function of circulation, however, remains its own master. If the myocardium ceases to discharge its function or the peripheral vessels undergo an alteration in tonus we are as helpless as ever. ... Of the causes of anoxia,, which is the ultimate cause of all death, we can control those which arise from the process of 'external' respiration. When 'internal' respiration or circulation fails, little can be done. At best we can only apply 'supportive measures' in good time.

"When we have the assistance of a chart which shows the variations in the patient's blood pressure and pulse rate we have no excuse for being taken unaware as to his condition. Should a sudden accident occur, we must be in a position to treat it effectively. As a rule this demands, not the cessation of the operation, but its completion in as short a time and with as little trauma as is consistent with mechanical efficiency.

"On innumerable occasions a mori-

bund patient has been successfully operated upon. He has recovered from the anesthetic. In some rare cases he has even made a complete recovery. . . . The experience of many such cases has brought me to believe that no patient is 'too ill' either to be operated upon, or to be anesthetized for the purpose provided the anesthetist is competent. It is, of course, true that a patient in extremis requires very little anesthetic; and if he is in coma no anesthesia is necessary as a rule. The ability to 'temper the wind to the shorn lamb' is an important attribute of the skilled anesthetist, for desperately ill patients cannot stand a relative overdose of an anesthetic agent. If a patient is so near death that he 'cannot' be anesthetized, then he is too ill to stand a surgical incision. We are concerned, then to ascertain how many patients may be expected to die during anesthesia. . . . This can only be determined by an examination of the records of large institutions. Records have been examined from five teaching hospitals in three different continents. Almost a quarter of a million cases are considered, and of these two hundred and eighty-three did not recover from the operation and anesthetic. . . . Two conclusions seem justifiable: (1) That if cases of all types in patients of all sorts and conditions are undertaken death before recovery is likely to befall about one patient in every thousand. (2) That the allocation of beginners to easy cases, the more experienced anesthetists being expected to deal with the graver cases and with the instruction of younger men, serves to reduce the incidence of fatalities.

Seven cases are reported of patients who did not survive operation. Only those two cases, in which the anesthetic was believed to be the cause of death, are recounted here.

"Case 4. May, 1934. A child of five was to have an appendectomy. The appendix was perforated and general peritonitis had set in, but the child was not as yet desperately ill. I performed the induction with an open ethyl-chlorideether sequence, this was uneventful. . . . Apparently the operation proceeded normally; the appendix was removed and the peritoneal cavity was drained. Anesthesia was by then fairly deep; probably of the third plane. A pharyngeal airway was in place, but no oxygen was being administered. The child's ears were slightly grey. Abruptly, as the surgeon picked up the peritoneum to sew it, respiration and circulation both ceased. The autopsy provided no explanation of the death.

Case 6. April, 1937. In this case death occurred before recovery from anesthesia, though not in the operating room. The patient was a very large, heavy man of twenty-four, on whose right ankle arthrodesis was to be performed. . . . Anesthesia was accomplished with open ether after an induction with ACE mixture. . . . The task of maintaining an unobstructed airway proved too much for the student. . . . The staff anesthetist therefore performed blind intubation. Maintenance of anesthesia was uneventful, though the anesthesia was deeper than the nature of the operation warranted. . . . Having returned to the ward, the patient developed periodic respiration of the 'Cheyne-Stokes' type. Whether this was due to pharyngeal obstruction or to some central cause is not clear. On two occasions apnea and cyanosis occurred but were successfully treated by the house and nursing staff. On the third occasion these methods failed, and when the anesthetist was able to leave the operating

room, some forty minutes later, he found the patient dead. At autopsy an unsuspected pericardial adhesion was found. . . .

"In cases 4 and 6 the anesthesia and not the operation was the cause of death. As far as one can judge on the evidence of others, I believe the child died of a relative hypoxia. She was suffering from peritonitis, her temperature was 102° and she therefore needed a large amount of oxygen. Although there was no respiratory obstruction she was sufficiently deeply anesthetized to have a marked reduction of respiratory exchange, and no additional oxygen was being given. Had she been fully oxygenated she would probably have survived. . . .

It would be easier to speak dogmatically as to the cause of death in case 6 if one had seen the behavior of the patient on his return to the ward. Descriptions by the nursing staff leave room for doubt whether the 'periodic' respiration was due to recurrent respiratory obstruction or to incipient medullary failure. The anesthetist in charge was to blame for allowing a student to take too much responsibility for a patient who was known to be difficult to manage. In view of the difficulty in maintaining a free airway the endotracheal tube should probably have been left in place until consciousness had been recovered. Instead of starting the next case the anesthetist should have remained with the patient and should have satisfied himself that anesthesia was light and that the freedom of the patient's airway was properly safeguarded before he left the operating room. These factors were probably of greater moment than the pericardial adhesion found at autopsy.

"Could these deaths have been prevented? . . . lighter anesthesia and ade-

quate oxygenation in case 4; light anesthesia and more careful attention to the airway in case 6 might have saved these patients."

RECOMMENDED READING

Readers who are not familiar with the use of curare are advised to read "Clinical and Laboratory Observations on the Use of Curare During Inhalation Anesthesia" by Stuart C. Cullen, Anesthesiology, Volume 5, Number 2, March 1944.

Jackson, D. E., M. D.: "Experimental and Clinical Observations Regarding the Border Zone Between Life and Death," Current Researches in Anesthesia and Analgesia., Volume 24, No.

1, January-February, 1945.

Archer, W. Harry: "Historical Sketch of Anesthesia 1844-1944," Current Researches in Anesthesia and Analgesia, Volume 23, No. 6 November-December 1944 and "Historical Sketch of Anesthesia 1844-1944 (Concluded)". Volume 24, No. 1, January-February, 1945.

Keys, Major Thomas E.: "Selected References for the History of Surgical Anesthesia," Current Researches in Anesthesia and Analgesia, Volume 24, No. 2, March-April, 1945. This article consists of an extensive bibliography on the history of anesthesia and on anesthetic agents, with a foreword by Dr. Howard Dittrick. It should be particularly useful to instructors and students.

Procedure for Intravenous Use of Pentothal Sodium in Dental Surgery

Pentothal Sodium has been used for dental surgery at St. Elizabeth Hospital in Danville, Illinois during the past two years. The results have been good. To perfect the technique to an even higher level is our objective. The procedure we use was developed after an interview with Doctor P. E. Hepner, surgeon, head of the Anesthesia Department at the time, and Doctor J. Honey, who was interested in the subject of the preparation for the type of patient described in later paragraphs. At this interview we agreed on a definite

—As followed at St. Elizabeth Hospital, Danville, Illinois, and reported by SISTER M. MIL-DRED SAUER O.S.F., Anesthetist.

pre-anesthetic preparation which is as follows:

The patient is admitted to the hospital the evening previous to the operation with a written report of the physical examination of heart, lungs, and blood pressure by the attending physician. On admittance one ampule of vitamin K is given. This is repeated on the morning of the operation. One nembutal capsule, grains $1\frac{1}{2}$ is given at bedtime for sleep. The coagulation, bleeding time, and a urinalysis is made routinely in the morning and breakfast is omitted. One-half hour before schedule time, morphine grain 1/6 and atropine grain 1/150 are given. (To robust patients nembuta grains $1\frac{1}{2}$ is given one and one half hour before schedule time and morphine grain $\frac{1}{4}$ may be ordered instead of the smaller dosage.)

The patient is taken to the operating room and placed in position without a pillow but has a small sand bag under the neck to throw the head back. The patient is draped with a sterile sheet and towels by a surgical nurse who remains during the entire operation to assist the surgeon. A nurse stands at the head of the patient to hold the jaw and aid the anesthetist when required. The arm is placed on a padded arm board and the area for venipuncture is prepared with alcohol. A tourniquet is applied. Then a 2.5 per cent pentothal

sodium solution is injected slowly by the anesthetist until the patient is asleep. Induction requires about 5-6 cc and more is given 1 cc at a time as needed for each patient.

A sterile intratracheal tube, which has been lubricated and attached to the tubing on oxygen, is then inserted through the nostril into the trachea, oxygen regulated at 3-5 liters. The dental surgeon inserts the throat pack and is ready for extraction. The suction machine is used to aspirate blood and the throat pack is changed as needed by the dentist. The intravenous is discontinued on request of the dental surgeon. He sprays the operative area with sulfathiazole powder as an antiseptic for the gums. The oxygen is discontinued and all bleeding is checked before the patient leaves the operating room. The syringe and needles are placed in a basin of distilled water after use until they are ready to be cleaned and resterilized on a special tray.

We like this method. We have had 189 patients treated in the past two years with excellent results.



This group were in attendance at the annual meeting of the Florida State Association of Nurse Anesthetists, about which further details appear in this issue under Association news.

Second Examination Program Scheduled for November; Membership Requirements Explained

By ANNE M. CAMPBELL, Executive Secretary, A.A.N.A.

THE FIRST qualifying examination for membership in the American Association of Nurse Anesthetists was given on June 4, 1945. There were 92 candidates and 90 participated in 39 hospitals in 28 states and one in Hawaii.

The inauguration of this program indicated that there is a great deal of confusion in the minds of members, officers of state associations, directors of schools of anesthesiology, and the applicants themselves, as to the part the examination plays in an applicant becoming a member of the American Association of Nurse Anesthetists and the amount of time involved in the process.

This article is an endeavor to clarify the purposes and procedures of the examination program and to outline the entire process which takes place in applying for membership in the A.A.N.A.

The Board of Trustees has set May and November as the months in which examinations will be held. November 19, 1945, is the date of the next examination. Announcements will be made in the JOURNAL of the dates of the examinations in each year. The passing of the examination is an ELIGIBILITY REQUIREMENT for membership in our Association, and in no sense, nor in any way, is it a STATE BOARD examination. Further, applications must

still go through the same routine of being passed upon by the state and national Committees on Credentials.

No application for membership is submitted to the national Committee on Credentials until a transcript of the applicant's school record is obtained from the school of anesthesiology from which she was graduated and unless the names of two active Members of the A.A.N.A. are given. From the transcript of her school record, the application itself and letters of reference, the Committee on Credentials decides whether the applicant has the necessary personal qualifications and if her courses in nursing and anesthesiology meet the Association's standards which entitle her to take the examination.

Many requests are received for permission to take the examination before the applicant has completed her course in anesthesiology. It is impossible to grant these requests. No application will be considered until the applicant has been graduated from her course in anesthesiology.

Applications are received in the Executive Office from the applicant herself

or from the secretary of a State Association. If the application is received directly from the applicant, a request is immediately sent to her school of anesthesiology for a transcript of her school record. At the same time, if she resides in an organized state, the application is sent to the secretary of the association in her state, for submission to that state's Committee on Credentials. When the transcript has been returned, completely filled out, it is held until the application has been passed upon by the State Committee, or vice versa, and the application and transcript forms are then forwarded to the National Committee on Credentials. An accurate record is kept of the dates on which the applications and transcript forms are sent out and when returned, so that it is known at all times. where these forms are and where there is a delay. A followup is instituted if there is a delay in returning either transcript or application.

The state and national Committees on Credentials usually meet once a month. It takes from six to eight weeks from the time an application is first received to obtain all necessary information and sond it to and receive it from the proper committees. It should be borne in mind that the Executive Office receives applications from the entire United States and its possessions and at times the volume of work is great both for the Executive Office and the national Committee on Credentials.

When applications are returned to the Executive Office by the national Committee on Credentials, applicants are immediately notified of the decision as to their eligibility. If they are found to be eligible for the examination, they are informed of the date of the next examination and are given thirty (30) days in which to send to the Executive Office

their \$15.00 examination fee and a signed photograph approximately 21/2 x 3 inches in size. When the examination fee and photograph are received, an outline of subjects for study and sample examination questions are sent to the applicant. As soon as the Committee on Examinations has selected the places for the examinations and appointed proctors, the applicant is notified as to where and to whom to report for the examination. Rules of the examination and her identification number are also sent to her. The number is the only identification of the applicant on her examination papers. Applicants receive this information at least one month before the examination.

A deadline date must be set beyond which no further applications for a particular examination can be considered. This is necessary in order to give the Committee on Examinations and the Executive Office sufficient time to prepare the final examination papers and to make arrangements with hospitals for space and secure the services of a proctor for each examination. This date will usually be six weeks prior to the date of the examination. After this deadline date no examination fees will be accepted for that particular examination. Therefore, if an applicant wishes to take a specific examination—for instance, the next one on November 19, 1945 her application should be received by the Executive Office on or about September 1, 1945 at the very latest. This will normally allow time for receipt of the transcript from her school and for consideration of the application by the necessary committees and give the applicant time to prepare for the examination.

The Standing Rules of the Association state: "The Executive Secretary

shall notify the candidate of the results of the examinations usually in about 90 days after taking the examinations." When all grades have been recorded in the Executive Office on the applicants' examination cards, the applicant will be informed as to whether she has passed or failed in the examination. No grades will ever be divulged to the applicant, her school of anethesiology, or anyone else. Her examination papers and grades will be kept in a confidential file under lock and key in the Executive Office and will be known only to the Executive Secretary and the person who records the grades and files the examination papers.

State Secretaries will be advised of the applicants in their states who have passed or failed in the examination. The State Secretaries have the responsibility of sending successful applicants a statement of dues and a copy of the By-Laws of the Association. The Executive Office sends a statement of dues and a copy of the By-Laws to applicants residing in unorganized states. Dues of newly accepted members are payable within thirty (30) days of the date of notification of their acceptance. If such notices are dated prior to March 1st of any year, dues for the full year will be payable by the new member. If the notice is dated after March 1st, the dues for that year are prorated and the new member pays only \$6.00 for the first year (1944 By-Laws, Article IX - Section 3).

From this explanation it will be understood that under the examination program it may take longer for an application for membership to be acted upon. It may be that in the future the process can be speeded up somewhat, but it should be kept in mind that the members of the Committees on Credentials

and the Committee on Examinations do this work on a voluntary basis, in addition to their regular duties, which in these days are very heavy. If the work is to be done conscientiously and thoroughly—and this is absolutely essential—it must take time, and only in this way can the high standards of the Association be maintained and justice be assured to those who are applying for membership.

Notes From the Executive Office

The newest type of office equipment has recently been purchased for this office. This includes Chaindex files for the mailing list, Kardex for the financial cards and Variedex, which is an improved filing system. We hope that these time and labor saving devices may help us in giving the members the most efficient service possible.

Growth of Membership

Year	Members
1933	397
34	664
35	923
36	1065
37	1350
38	1632
39	1910
40	2151
41	2363
42	2565
43	2786
44	3094



RAGNA P. WIGEN of St. Luke's Hospital, Spokane, Washington, is the new president of the nurse anesthetists in her state.



IRENE BOYLES of Memorial Hospital, Charlotte, N. C., heads the nurse anesthetists in her state, as president of the state-wide group.



VERA COPELAND, St. Elizabeth's Hospital, Richmond, heads the Virginia State Association of Nurse Anesthetists as this year's president.



GERTRUDE MYERS, St. Mary's Hospital, Detroit, is the new president of the Michigan State Association of Nurse Anesthetists.

ASSOCIATION News State and National

Washington . . .

The seventh annual meeting of the Washington State Nurse Anesthetist Association was held at the Davenport Hotel, Spokane, Washington, May 12,

1945, at two-thirty P.M.

Preceding the business meeting was a luncheon, at which the members were welcomed by Dr. Remington, President of the Spokane Medical Society. Dr. Joseph Lynch, who is Director of the School of Anesthesiology at Sacred Heart Hospital, Spokane, Washington, gave an interesting talk concerning the various anesthetic agents, their use and effects.

President Sylvia Chapman called the business meeting to order. Thirty-four members answered roll call. The minutes of the last two meetings and treas-

urers reports were read.

It was moved and seconded that the books be audited by a qualified accountant. At this point it was moved and seconded that Marcella Wilhelmy be paid for the auditing of the books for the previous year which she paid out of personal funds.

New business included the election of officers. Tellers were Rose O'Neill, E:ther Rudkin, Marian Gage. The fol-

lowing were elected:

RAGNA WIGEN, president; MARGUERITE LAYTON, vice president; ALICE SELLARS ZELSKI, SECRETARY; NETTA PEEL HOGUE, treasurer. Board of Directors: ELIZABETH SCULLY, NORA DELL.

There was a discussion concerning the payment of dues for members who are serving with military forces overseas. It was decided that Washington State Association will pay the dues of such members if the American does not do so, until such members return to the U.S.A.

Following a discussion relative to a state pin, the president appointed a committee to arrange for one.

It was regularly moved and seconded that Miss Alice Claude be accepted as an honorary member to the association with the State of Washington Association paying her dues.

Rose O'Neill was named chairman of the Advisory Board, she to appoint her

own committee.

There was a discussion of revision of the by-laws but the final decision was

negative.

A Hospitality Hour at the Davenport Hotel at 6:30 P.M. was followed by a banquet which was well attended and enjoyed by all.

Oregon . . .

The final meeting for the year of the Oregon Association of Nurse Anesthetists was held on May 21, at the Good Samaritan Hospital Graduate Home, Portland.

Dr. J. F. Paquet gave an informal lecture on "Drugs of Interest to the Anesthetist." The lecture was followed by a lively discussion.

President Ruth Schierman conducted the business meeting. The annual reports of the secretary and treasurer were

read and approved.

Marie K. Fast, a member of the association who was with UNRRA in Egypt, has been reported missing, almost certainly lost at sea. As a memoriam to Miss Fast the members voted to send \$25 to her sister, Agenehta Fast, to help her in her work as a missionary.

The association voted to forego the annual banquet and spend the money on an educational film for the new projector at the Dornbecker Childrens Hospital.

After the election of officers the meeting was adjourned and refreshments

were served.

Officers elected were: ELIZABETH JOHNson, 2417 E. 12th St., Portland 14, president; AIMEE DOERR, Vanport City Hospital, Portland 17, 1st vice president; JEANNE FAGAN, 3018 N. E. 43rd St., Portland 13, 2nd vice president; SR. Agnes DE BOHEME, St. Vincent's Hospital, Portland 10, historian; Mrs. FLORENCE J. SHELTON, trustee for three years.

The April meeting of the Oregon Association of Nurse Anesthetists was held on Tuesday evening, April 27, at St. Vincent's Hospital Nurses Home, Portland. Eleven members were present and attended a program presented by the Cadet Nurses of St. Vincent's Hospital.

At the business meeting it was decided to dispense with the annual banquet and use the funds for an entertainment at one of the children's hospitals in Porland.

Mrs. Loretta Case presented a paper on Demoral.

Alabama . . .

The annual meeting of the Alabama Association of Nurse Anesthetists was held on Thursday evening, May 10, in the Flamingo Room of the Tutwiler Hotel, Birmingham. President Edith B. Allen presided.

Following the dinner Dr. Hiram Elliott of the Tennessee Coal, Iron and Railroad Company Hospital spoke on "Anesthetic Agents, Indications, Contra-Indications and Premedication.'

At the business meeting, which followed Dr. Elliott's talk, the minutes of the last meeting and the treasurer's report were read and approved. There was a discussion of the possibility of more frequent meetings, in order to keep the

members better informed on new methods and the uses of various anesthetic agents. No decision was reached. The purchase of two \$100 war bonds was

approved.

Officers elected were: THELMA A. NELSON, 918 So. 30th St., Apt. 1A, Birmingham 5, president; Louise V. Cook, Jefferson Hospital, Birmingham 5, vice president; Alberta Boggan, 1014 Essex Rd., Birmingham, secretary; Ruby WALKER, Jefferson Hospital, Birmingham, treasurer.

Illinois . . .

A meeting of the Illinois State Association of Nurse Anesthetists was held Tuesday afternoon, May 8, at Mercy Hospital, Chicago.

Dr. John L. Keely, staff member of Mercy Hospital, Chicago, spoke on

"Shock."

The following officers were elected: ELIZABETH D. ZECH, Evanston Hospital, Evanston, 1st vice president; BURLIE P. EGGLESTON, 40 E. Oak St., Chicago 11, secretary; EMELIA J. ZENDER, historian; OPAL SCHRAM, trustee.

Massachusetts . . .

The annual meeting of the Massachusetts State Association of Nurse Anesthetists was held May 21, at the home of Shina Ritchie, 39 Moody Street, Chestnut Hill. Twelve members were present. The treasurer reported a balance on hand of \$334.75.

Betty Lank, Chief Anesthetist of Children's Hospital, Boston, read an interesting and instructive paper on "Anesthesia for Infants." Refreshments were served by the hostess at the end of the

meeting.

Officers elected were: ELIZABETH MAC-RAE, Peter Bent Brigham Hospital, Boston 1, president; MADELINE HUNT, 14 Pierrepont Rd., Newton Lower Falls 62, 1st vice president; RUTH H. ARMITAGE, 24 Damien Rd., Wellesley, 2nd vice president; Mrs. Eva MacArthur, 80 Glen Rd., Brookline 46, secretary-treasurer. Trustees: Rose Sbarra, Velma Whitney.

Michigan . . .

Officers of the Michigan Association of Nurse Anesthetists elected, May 5, 1945, were: Mrs. GERTRUDE MYERS, St. Mary's Hospital, Detroit 21, president; E. Louise Ilgenfritz, 1340 E. Grand Boulevard, Detroit 11, 1st vice president; EVELYN Y. BUFERD, St. Mary's Hospital, Detroit 21, 2nd vice president; Mrs. ELIZABETH BLANCHARD, 19229 Yacama Road, Detroit 3, secretary; Ione Wes-SINGER, 2800 West Grand Boulevard, Detroit 2, treasurer. Later, Mrs. Blanchard resigned, and Miss Wessinger assumed the secretaryship in combination with her duties as treasurer for the time being.

Minnesota . . .

The annual meeting of the Minnesota Association of Nurse Anesthetists was held Friday, May 4, at the Nicollet Hotel, Minneapolis. There were 37 members and 20 visitors present.

New officers elected were: Ellen Lonergan, Ancker Hospital, St. Paul 5, vice president; June Winquist, Swedish Hospital, Minneapolis 4, secretary. Trustees: Hazel Peterson (1945-47), Ruth Kiely (1945-47), Mrs. Elizabeth Gaertner (1944-46), Mrs. Sophie Gano (1944-46).

Delegates to the National Convention, if held, are: Ruth Bergman, and Ruth Kiely. Alternates are Elizabeth Gaertner, Martha Lundgaard, and Florence A. McQuillan.

North Carolina . . .

Officers elected by the North Carolina Association of Nurse Anesthetists are: IRENE BOYLES, Memorial Hospital, Charlotte, president; CARRIE E. SMITH, Baker Sanitarium, Lumberton, vice president; MARY B. CAMPBELL, Duke University Hospital, Durham, secretary-treasurer.

Nebraska . . .

The newly elected secretary-treasurer of the Nebraska Association of Nurse Anethetists is, Dolores V. Broughton, Immanuel Deaconess Hospital, Omaha.

New Jersey . . .

Due to the curtailment of traffic, controlled by the Office of Defense Transportation, there will be no general assembly of the New Jersey State Association of Nurse Anesthetists until further notice, Mrs. Dorothy N. Ball, secretary-treasurer, has announced in a formal notice to the membership.

Mrs. Ball has mailed to the membership a detailed report covering her work as secretary and treasurer. It follows:

REPORT OF THE SECRETARY

REPORT OF THE SECRETARY
May 31, 1945.
Members in good standing
May 1, 1944
May 1, 1945
May 1, 1944 o members
May 1, 1945 3 members
Deaths o members
Resignations I member
Address unknown o members
Members transferred to New Jersey
State Association 7 members
Members transferred from New Jersey
State Association 15 members
New members 5 members
Members transferred from Active
to Inactive membership o members
Applications accepted but dues
not paid o members
Applications pending in New Jersey
State Ass'n Membership Comm o members
Applications pending in American
Ass'n Membership Comm 1 member
Applications deferred 1 member
A Track of the I

Applications rejected I member

REPORT OF TREASURER

Balance, May 1, 1944	\$	177.18
Receipts:		
Dues	\$1042.00	

Dues (Transfer to New Jersey State		
Association)	15.00	
Initiation fees	14.00	
Convention: Registration fees -		
Banquet fee	131.98	
Money received on Bond chances	284.65	
Money deposited (Taken from Treas-		
ury for convention trip and not		
needed)	41.78	
		\$1529.91
Disbursements:		4.1.1
Remittance of dues to American		
Ass'n of Nurse Anesthetists\$	660.00	
Initiation fees to American Ass'n	009.00	
of Nurse Anesthetists	14.00	
New Jersey State Hospital affiliation	24.00	
dues	19.00	
Expense on Bond chances	56.96	
To New York State Association	6.88	
State and Americal Ass'n Convention	0400	
expenses	196.64	
Refund of dues	.50	
Trust fund for 1933 and 1934	13.90	
Office expenses	104.64	
Bank service charges	9.86	
	41.93	
2 April 1944 cancelled checks	41.93	\$1133.31
Dalance Man e sous		
Balance, May 1, 1945		. 573.70
Represented by:		
Balance on deposit, The First National		
of Highland Park, N. J		.\$ 573.78

Pennsylvania . . .

The annual report of the secretary of the Pennsylvania State Association of Nurse Anesthetists lists 337 members in good standing at the close of the fiscal year, April 1, 1945. Forty-five of the members of the Pennsylvania group are in the armed forces, Secretary Helen Young Walker reports.

A progressive step in good management has been taken by the Pennsylvania State Association of Nurse Anesthetists in connection with it's treasurer's report. This report, not only has been audited by Certified Public Accountants, but has been opened for general inspection in brochure form. It is reprinted in full:

APRIL I, 1944 TO MARCH	31, 1945
PENNA. ASSOCIATION OF NURSE	ANESTHETIST
STATEMENT OF RECEIPTS AND I	DISBURSEMENT
APRIL 1, 1944 TO MARCH	31, 1945
Balance, April 1, 1944	\$2,367.2
Receipts:	
Dues\$3	.898.00
Initiation Fees	
Fines	3.00
Dues Received from American As-	
sociation for members transferred	
into state	31.00
Dues Overpaid by members	6.00
Interest Received, Philadelphia Saving	
Fund Society	
Total Receipts	4,029.0

Disbursements:		
Remittances to American Association of Nurse Anesthetists:		
Dues\$	2,460.25	
Initiation Fees	50.00	
Convention Expenses	209.84	
Office Expense	91.01	
Donations American Red Cros	25.00	
Donations	15.00	
Board	10.00	
Refund to District Association, Dues	25.00	
Refund to District Association, Fees.	2.00	
Penalty	3.00	
Trust Fund Payment	31.80	
Christmas Gifts	15.75	
Fidelity Bond, Secretary and		
Treasurer	5.00	
Overpaid Dues	6.00	
Membership Committee	5.00	
Central Penn. National Bank Charge	2.28	
Total Disbursements		2,956.93
Balance, March 31, 1945		\$3,440.26
Represented By:		
Balance on deposit - Central Penn	Nationa	1
Bank		
The Philadelphia Saving Fund Society		. 1,081.38
\$300. United States Government Defe		
Series "F" due 5/1/54 (cost)		. 222.00
\$500. United States Government Defe		
Series "F" due 6/1/55 (cost)		
\$300. United States Government Defe		
Series "F", due 6/1/56 (cost)		
		\$3,440.26

Texas . . .

Dichurcomente

OPA travel regulations state that no convention of over 50 persons may be held. The Texas Hospital Association applied for special permission to hold their annual meeting, but the application was rejected. Therefore, it was necessary for the Texas Association of Nurse Anesthetists to cancel their annual meeting also.

The Board of Trustees of the Texas Association of Nurse Anesthetists has circulized each member on the activities of the American and Texas Associations for the past year, since it was not possible to hold the meeting.

The Board of Trustees, Texas Association of Nurse Anesthetists, met in Dallas, April 7th and 8th to transact the business of the state for the past year, and to get ready for the coming year. Members present were: Mrs. Gertrude E. Baker, president; Winnifred Hackworth, vice president; Mrs. Jack K. Childress, sec-treas.; Mrs. Jessie Compton, Dorothy Hoadley, Laura Hoffman, and Thelma Watkins, trustees.

Mrs. Gertrude Baker, president for the past two years, presented her resignation, and Winnifred Hackworth be-

came the new president.

Officers for 1945-46 are: WINNIFRED HACKWORTH, 1317 Pierce, Houston, president; Mrs. Jessie Compton, 702 Winston, Dallas, vice president; Mrs. JACK CHILDRESS, 716 W. Ave. "G", Temple, secretary-treasurer; MINNIE V. HAAS, historian. Trustees: Dorothy HOADLEY, LAURA HOFFMAN, MRS. THELMA WATKINS, MARTHA DELAY.

The Texas Association voted last year to pay the dues of the members from the state in the Service, Overseas. The following dues were paid by the State Association: Zelma Alvey, Helen Didner, Vanda Kibler, Evelyn K. King, Margaret C. Moore, Sarah Rausch, Grace Warren, Edythe McDonald.

Committee Chairmen include: Jean Wright, membership; Annie Bohls, finance; Rosa Timmerman, legislative; Louise Houls, Revisions. Other chairmen for program, arrangements, and educational are yet to be appointed.

Following is a list of members that are in the Service in the States from this group: (If any have been omitted it is unintentional. Please write to Mrs. Jack K. Childress, 716 W. Ave. G, Temple, Texas, if the list is not complete.) Mamie L. Baker, Dorothy Jean Barber, Capt. Mildred I. Clark, Mrs. B. L. Cornell, Delphine E. Franson.

The Texas Association of Nurse Anesthetists is proud to be the owner of

eight \$100 War bonds.

Florida . . .

The Florida State Association of Nurse Anesthetists has contributed \$10 to the Library Fund, \$5 for 1944 and

\$5 for 1945.

The annual meeting of the Florida State Association of Nurse Anesthetists was held June 2-3, 1945 at the Mac-Fadden Deauville Hotel, Miami Beach, Florida, opening with a dinner program the evening of the first day, Mrs. Mary C. Brown, presiding. The program included talks by Phelia Ponder, Thomas F. Smith, and Major Walter Freeman. Mrs. Fannie Smoyer and Mrs. Anna Dunham Thiel entertained

with a musical program.

During the business sessions, President Alpha E. Schier called for the reports of officers and committee chairmen; a report of the annual meeting of the A.A.N.A. held in Cleveland was given by Mrs. Carol Elmore, who presented for discussion several important subjects. The group voted to endorse the Blue Cross Hospital Plan, discussed membership in the state-wide organizations of anesthetists; urged members to attend the Institute for Anesthesiologists, and formulated plans for group meetings in the state.

The social program included an early morning beach and pool party

before breakfast Sunday.

The following papers on professional subjects were delivered during the

course of the meeting:

"The Oral Surgeon's Appreciation of Nurse Anesthetists," by William G. Sanchez, D.D.S., Dental College, Emory University, Atlanta, Ga.

"Caudal Anesthesia," by George Williams, Jr., M.D., Harvard Medical

School.

"Curare in Anesthesia," by Bessie Simpson French, M.D., anesthetist, University of Illinois, Urbana, Ill., and House Anesthetist and House Surgeon, Sheffield Royal Hospital, Sheffield, Eng-

"Welfare Work, Rehabilitation of Women," Col. Agnes McKernon, Salvation Army, New York City.

Tennessee . . .

The Tennessee Nurse Anesthetists Association will be served by the following officers during 1945:

MRS. ALBERTA SULLIVAN, president; NETTIE BRYANT, 1st vice president; Mrs. JIMMY TERRY SHENEP, 2nd vice president; Mrs. Elaine Hanne, secretary; MRS. WAVERLY W. WHITE, treasurer; ALICE SIMS, historian. Board of trustees: MRS. LUCILLE HILL, one year; WILLIE MAE MULLIN, two years; MRS. DOROTHY LA RUE DAFFIN, three years; MARY ELLEN McCue, four years.

The board of directors met February 26th, 1945, to fill vacancies on the Board left vacant by resignation of the secretary and members being trans-

ferred to other states.

At this February meeting the resignation of the Secretary-treasurer Theresa W. Trail was accepted. Since the Association has grown in the last couple years, the by-laws read that both a secretary and treasurer could be elected it was decided to appoint a secretary and a treasurer to lighten the work of the combined officer.

The secretary-treasurer's report included this data: As of January 1, 1945, Active members, 96; New members 1944, 8; Delinquent members, 1; Members dropped, 2; Members transferred to State, 9; Members transferred from State, 11; Applications pending, 8; Applications deferred, 1; Applications rejected, 3; Bank balance Jan. 1, 1945, \$896.92.

Virginia . . .

New officers of the Virginia State Association of Nurse Anesthetists are: Vera Copeland, president, St. Elizabeth's Hospital, Richmond; Mrs. Gertrude Cassler Mann, vice president, Stuart Circle Hospital, Richmond; Beatrice H. Wilson, secretary-treasurer, McKim Hall, Charlottesville. Trustees: Mrs. Clara Hudgins, Mrs. Hazel Bagby Wells.

The tenth annual meeting of the Virginia State Association of Nurse Anesthetists was held in the Monroe Room of the John Marshall Hotel, Richmond, Va., May 26, 1945 with nineteen members and three visitors in attendance.

The business meeting was called to

order by President Georgia Scott of Lewis Gale Hospital, Roanoke, Virginia. Reports were heard from the secretary, treasurer and committees. It was decided that the Association should buy \$500 worth of War Bonds.

The Program Committee presented Major R. C. Siersema who spoke on, "Anesthetics used by 8th Evacuation Hospital in Italy"; and Mrs. Nancy Broughton who discussed, "Sodium Pentothal Anesthesia." A Round Table conducted by Miss Scott followed.

Tea was enjoyed by members and visitors following the meeting.

The report of the treasurer, Elsie W. Lawhorne follows:

Balance in bank May 1, 1944\$	520.05
Receipts for dues received May 1, 1944- May 25, 1945	713.00
_	

Disbursements, May 1, 1944-	,233.05
May 25, 1945: Transferred to Amer. Assoc. of N. A\$ Paid to Trust Fund Refund (2) dues (\$3.00 each)	4.90 6.00 18.00
Typing—Miss Scott	5.00 6.35

Marie K. Fast

Balance in Bank ...



MARIE K. FAST lost her life May 1, 1945 when the ship on which she was travelling on a special war assignment was hit by a high explosive and sank

off the coast of Egypt.

Miss Fast was born near Mountain Lake, Minnesota and graduated from Mennonite Hospital Training School in Beatrice, Nebraska. She completed her training in Anesthesia at Grace Hospital, Detroit, and was a member of the anesthesia staff at Good Samaritan Hospital, Portland, Oregon from 1941 until 1944. She volunteered to the Mennonite Central Committee for war relief work and was sent to Egypt by the U.N.R.R.A. When her ship sank she was accompanying Yugoslavia refugees back to their country from Egypt. The life boat to which she was assigned tipped and threw her into the water.

SECOND LIEUTENANT FLORENCE TAYLOR GREWER was "killed in action" according to word received from the War Department recently, the Washington State Nurse Anesthetists Association, of which she was a member, advises. Mrs. Grewer was a graduate of Northwestern Hospital, Minneapolis, Minn. It is understood from unofficial sources that she was assigned to the U.S.S. Comfort which figured prominently in newspaper reports of ship sinkings during recent weeks.

New Editor for Journal of A. A. N. A.

Effective with this August 1945 issue of The Journal of the American Association of Nurse Anesthetists, Martha Dunlap has assumed the position of Editor and Advertising Director. She succeeds H. C. Combs who has resigned due to pressure of other interests.

Miss Dunlap is a professionally trained journalist. She is a graduate of Montana State University holding the degree of B.A. in Journalism and has done post-graduate study at Northwestern University. Her experience includes a varied background in newspaper work, advertising, trade association, publicity and public relations. For the past ten years she has been editor and advertising manager of a nationally circulated monthly trade journal in the transportation industry. She is active in several professional groups including: The Women's Advertising Club of Chicago; Industrial Editors Association; Publicity Club; Trade Association Executive's Forum.

Edith-Helen Holmes, chairman of the publishing committee, in announcMartha Dunlap, Editor



ing Miss Dunlap's appointment again stresses to the membership the need for their collaboration in maintaining The Journal as an outstanding technical and news publication covering the highly specialized work of the nurse anesthetists. Miss Holmes points out that under the new editor there will be gradual and constant changes and improvements in the magazine's format and content. These will be accelerated by constructive comment which, it is hoped, readers will offer from time to time.

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Morpheus, the versatile God of Dreams, was delegated to watch over Hypnos as he slept to fend off harm and insure pleasant dreams. In the seal he is shown holding aloft the Lamp of Learning by the light of which he keeps his vigil.

This legend, interpreting the design, will be wrapped with each pin, with the thought that knowing the story which inspired the design will add to its enjoyment.

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AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

OFFICIAL EMBLEM

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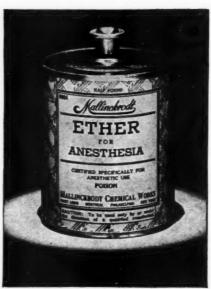
NAME		
STREET ADDRESS		
CITY	STATE	OCCUPATION OF THE PROPERTY OF
HOSPITAL		*****
August 1945		47

WHAT'S THE first anesthetic YOU THINK OF?

IN ALL surgery the name ETHER has come to be a synonym for anesthesia.

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Institute for Instructors of

Anesthesiology

PLACE AND TIME: It is now definite that the Institute for Instructors of Anesthesiology will be held at the Knickerbocker Hotel, Chicago, the week beginning October 8, 1945.

CERTIFICATE: An attractive certificate will be presented by the American Association of Nurse Anesthetists to each member who has attended all of the sessions. Registrants are, therefore, urged to make every effort for 100 per cent attendance.

NUMBER OF REGISTRANTS ALLOWED: At this time of writing (July 15) there have been 125 applications received and no change has been made in the government ruling that the registration must be limited to 50 outof-town members. If an increase in the number is not permitted by September 10, the registration fees will be returned to those applicants who cannot be accommodated. From now on, anyone wishing to attend the Institute may indicate her desire by sending the application (Page 55 in May Journal) to Mrs. Esther Myers-Stephenson, 7 Wolcott Road, Winchester, Mass., but please DO NOT send any money. If a larger registration is allowed, these applicants will be notified and their full registration fee may be paid at the Institute.

ELIGIBILITY: The letter announcing the Institute was sent to the mem-

bers by second-class mail. For this reason there was a marked difference in the time that the members were notified. In fairness to members in all States, applications of anesthetists not affiliated with schools of anesthesiology from the various States will be considered and accepted in the order in which they were received.

RESERVATIONS: Hotel reservations will be made at the Knickerbocker Hotel for registrants and every effort will be made to secure the type of accommodation requested. The room will be reserved for the date indicated on the application form.

REGISTRATION: A notice will be posted in the lobby of the Hotel indicating the whereabouts of the Institute Registration Desk. Registration hours will be on Sunday from 4 P.M. to 8 P.M. and Monday 7:30 A.M. to 8:30 A.M. Registrants of the Institute are asked to register on Sunday if possible.

FACULTY

HAZEL BLANCHARD, President, American Association of Nurse Anesthetists; Chief Anesthetist, Samaritan Hospital, Troy, New York.

IRENE BOYLES, Member of Public Relations Committee, American Association of Nurse Anesthetists; President, North Carolina Association of Nurse Anesthetists; Chief Anesthetist, Charlotte Memorial Hospital, Charlotte, North Carolina.

MAE B. CAMERON, Chairman, Tri-

State Assembly for Nurse Anesthetists; Director, School of Anesthesiology, Ravenswood Hospital, Chicago, Illinois.

ELIZABETH COLEMAN BLANCHARD, Former Chief Gas Therapist and Instructor, School of Anesthesiology, Mount Carmel Mercy Hospital, Detroit, Michigan.

MABEL COURTNEY, Member of Post War Problems Committee, American Association of Nurse Anesthetists; Instructor, School of Anesthesiology, Grace Hospital, Detroit, Michigan.

Gertrude Fife, Treasurer, American Association of Nurse Anesthetists; Director, School of Anesthesiology, University Hospitals, Cleveland, Ohio.

Edith-Helen Holmes, Chm., Publishing Committee, American Association of Nurse Anesthetists; Director, School of Anesthesiology, Norwegian-American Hospital, Chicago, Illinois.

HUGO V. HULLERMAN, M.D., Secretary, Council on Professional Practice, American Hospital Association, Chicago, Illinois.

HELEN LAMB, Chairman, Educational Committee, American Association of Nurse Anesthetists; Director, School of Anesthesiology, Barnes Hospital, St. Louis, Missouri.

LEO M. LYONS, Director, St. Luke's Hospital, Chicago, Illinois.

MALCOLM T. MacEachern, M.D., Associate Director, American College of Surgeons; Chairman, Council on International Relations, American Hospital Association, Chicago, Illinois.

Janet McMahon, Member of Curriculum Committee, American Association of Nurse Anesthetists; Instructor, School of Anesthesiology, University Hospitals, Cleveland, Ohio.

RAYMOND L. McNEELY, M.D., Sur-

geon, Wesley Memorial Hospital, Chicago, Illinois.

Gertrude Myers, Director, School of Anesthesiology, St. Mary's Hospital, Detroit, Michigan.

OPAL E. SCHRAM, Member of Publishing Committee, Instructor, School of Anesthesiology, Wesley Memorial Hospital, Chicago, Illinois.

SISTER SERAPHIA, Instructor, School of Anesthesiology, St. John's Hospital, Springfield, Illinois.

ELETTA ENGUM SILVER, Former Director, School of Anesthesiology, Mount Carmel Mercy Hospital; Member of Curriculum Committee, American Association of Nurse Anesthetists, Detroit, Michigan.

MIRIAM SHUPP, Chairman, Examination Committee, American Association of Nurse Anesthetists; Chief Anesthetist, Strong Memorial Hospital, Rochester, New York.

MARY H. SNIVELY, Director, School of Anesthesiology, Duke University Hospital, Durham, North Carolina.

ESTHER MYERS - STEPHENSON, Chairman, Institute Committee, American Association of Nurse Anesthetists, Winchester, Massachusetts.

MARGARET SULLIVAN, Chairman, Records Committee, American Association of Nurse Anesthetists; Chief Anesthetist, Roosevelt Hospital, New York, New York.

SISTER MARY LASALETTE RUDDY, R.S. M., Member of Institute Committee, American Association of Nurse Anesthetists; Instructor, School of Anesthesiology, Mount Carmel Mercy Hospital, Detroit, Michigan.

ALMA WEBB, Chairman, Curriculum Committee, American Association of Nurse Anesthetists; Instructor, School of Anesthesiology, Baylor University Hospital, Dallas, Texas.

PROGRAM

MONDAY, OCTOBER 8

7:30 to 8:30 A.M.—Registration

9:00 to 12 Noon —Greetings to the Institute

American Association of Nurse Anesthetists, Hazel Blanchard

American Hospital Association, Dr. Hugo V. Hullerman Lecture: "Principles and Methods of Teaching" by: An Authority

Lecture: "Physiology of Circulatory System," Esther Myers-Stephenson

2:00 to 5:00 P.M.—Panel Discussion: "The Nurse Anesthetist's Plans for Tomorrow's Responsibilities"

Coordinator—Dr. Malcolm T. MacEachern

Director of Nursing Education-

Surgeon—Dr. Raymond L. McNeely

. Physician-Anesthetist-

Educator-

Administrator-Leo Lyons

7:00 to 9:00 P.M.—Lecture: "Principles and Methods of Teaching" by: An Authority

Discussion: "Physiology of Circulatory System"

TUESDAY, OCTOBER 9

9:00 to 12 Noon —Lecture and Discussion: "Endotracheal Anesthesia," Helen Lamb

> Lecture and Discussion: "Signs of Anesthesia," Janet McMahon

2:00 to 5:00 P.M.—Ravenswood Hospital: Tour and Study of Physical set-up of School of Anesthesiology, Departments of Anesthesa and Gas Therapy," Mae B. Cameron

> Round Table Discussion: "Administration of Anesthetic Agents and Allied Drugs"

Pentothal Sodium—Irene Boyles

Curare-Mable Courtney

Spinal Anesthesia-

Avertin with Cyclopropane-Mae B. Cameron

Group Discussion: "Resuscitation and Resuscitators"

7:00 to 9:00 P.M.—Lecture: "Principles of Curriculum Construction" by: An Authority

August 1945

WEDNESDAY, OCTOBER 10

9:00 to 12 Noon —Lecture and Discussion: "Medications," Sister Mary La-Salette Ruddy

Lecture and Discussion: "Organization and Management of a Department of Anesthesia," Gertrude Fife

THURSDAY, OCTOBER 11

9:00 to 12 Noon —Lecture and Discussion: "Accidents Pre, During, and Post Anesthesia," Eletta Engum Silver

Lecture and Discussion: "Ethyl Chloride," Gertrude Myers

2:00 to 5:00 P.M.—Symposium: "Organization of a School of Anesthesiology"
Organization—Sister Seraphia

Faculty-

Facilities-Mary Snively

Records-Esther Myers-Stephenson

Student Entrance Requirements—Edith-Helen Holmes Functions of a School Affiliated with a College—Eletta Engum Silver

Curriculum—Alma Webb

7:00 to 9:00 P.M.—Lecture: "The Essentials in Writing a Paper on Anesthesia" by: An Authority

FRIDAY, OCTOBER 12

9:00 to 12 Noon —Lecture and Discussion: "Gas Therapy," Elizabeth Cole-

Demonstration and Discussion: "Anesthesia Department Records as recommended by the Record Committee of the American Association of Nurse Anesthetists," Margaret Sullivan

2:00 to 5:00 P.M.—Wesley Memorial Hospital: Tour and Study of School of Anesthesiology, Departments of Anesthesia and Gas Therapy, Opal E. Schram

7:00 to 9:00 P.M.—Information Please: "The Curriculum as Recommended by the Curriculum Committee of the American Association of Nurse Anesthetists," Alma Webb, Janet McMahon, and Eletta Engum Silver

9:00 P.M.—Social Hour

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SATURDAY, OCTOBER 13

9:00 to 12 Noon —Information Please: "The American Association of Nurse Anesthetists Qualifying Examination," Miriam Shupp Award of Certificates.

MEMBERS AMERICAN ASSOCIATION OF NURSE **ANESTHETISTS**

JULY, 1945

KEY TO SYMBOLS

President State Association

Secretary State Association

Inactive Member

Service

Last Dues Paid 1944

In compliance with the orders issued by the Office of Censorship, Washington, D. C., we are not publishing service addresses for members overseas.

ALABAMA

Allen, Mrs. Edith B. Allen, Lola Ames, Juanita Barnes, Lt. Hattie M. USNR U. S. Naval Hospital

Benefield, Mrs. Lois P. **Boggan, Alberta Campbell, Lt. Bernice Cook, Mrs. Mary E. Cooke, Louise V.
Couch, Inez
Currie, Willie Bruce
Davis, Mrs. Boykin
Donk, Louise
Filiatt Cornelia Elliott, Cornelia Engelland, Violet E. Foust, Mrs. Alma C.
Gamble, Lt. Flossie
ANC-N-763803 Getty, Mrs. Edith S.

Hartin, Annie P. Hester, Allene Hill, Mrs. Emily McC. Hollum, Annie L. #Hughes, Mrs. Ruth H.

Hagel, Dolores

Grantham, Mrs. Mary S.

Lindsey, Mrs. Grace V. Maenner, Rosa E. McLain, Jewell Morris, Mrs. Nell Gandy Nelson, Lt. Edna Earl

*Nelson, Thelma O'Dell, Mrs. Mary J. O'Reilly, Mrs. Thelma Orr, Mrs. Zadie Lou Parks, Mary Blande Pepe, Mrs. Gertie B. Philen, Della Iva

TCI Hospital McNease & Robinson Hospital Fayette Highland Av. Baptist Hospital Birmingham 5 Navy Yard 1316 Springhill Ave. 1014 Essex Road 250 Austin Drive, Rt 2 Eliza Coffee Memorial Hospital Florence Jefferson Hospital Citizens Hospital Jefferson Hospital 815 S. St. Andrews St. Colbert County Hospital **Huntsville Hospital** 1141 S. 14th St. Colbert County Hospital A.S.F. Regional Hospital

306 N. Bayview Ave. 408 S. 4th St. **Baptist Hospital** West End Unit Memorial Hospital 1155 Springhill Ave. Hill Hospital Sylacauga Hospital The Berkeley 2124 Highland Ave. Anniston Memorial Hospital 59 LeMoyne Place Jefferson Hospital 1421 N. 24th St. c/o Surgery,

Moore General Hospital 918 South 30th St. Apt. 1 3616 Mountain Lane Spry Funeral Home 421 Goodwin Ave. Druid City Hospital West End Baptist Hospital 2163 Highland Ave.

Fairfield Charleston, S. C Mobile 17 Birmingham 5 Decatur, Ga. Birmingham 5 Talladega Birmingham Dothan Sheffield Huntsville Birmingham 5 Sheffield Camp Blanding, Fla. Fairhope Gadsden Birmingham 7

Andalusia Mobile 16 York Sylacauga Birmingham 5

Anniston Mobile 17 Birmingham 5 Birmingham 4 Swananoa, N. C. Birmingham 5 Birmingham 9 Florence Anniston Tuscaloosa Birmingham 7 Birmingham 5

Rice, Verna M. Rushing, Mrs. Evelyn P. Scott, Mrs. Lida Sister M. Paulette Foley Siura, Esther B. Swetman, Minnie E. Traber, Anna Walker, Ruby Wilson, Bess

2508 St. Stephens Rd. 2030 S. 9th Ave., Apt. 1 313 East Williams St. Holy Name of Jesus Hospital Gadsden Box 182 U. S. Marine Hospital 2020 11th Ave. Jefferson Hospital King Memorial Hospital

Mobile 17 Birmingham 7 Huntsville Grand Bay Mobile 16 Birmingham 5 Birmingham 5 Selma

ARIZONA

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2418 Eastwood Ave. St. Bernard's Hospital 6337 Harvard Ave. Oak Park Hospital 2420 N. Kedzie Ave Illinois Central Hospital 5800 Stony Island Ave. St. Joseph's Hospital 2121 Burling St. Mother Cabriani Hospital 1200 Cabriani Place 824 W. Aldine Ave. 2318 W. Irving Park Road 518 N. Austin Blvd. West Washington St., Rt. 2 40 East Oak St. 925 Montrose Ave.

4926 Crystal St. 2229 Touhy Ave. Bks. 1043 Station Hospital

Silver Cross Hospital 449 Winneconna Parkway 7 Wasp Rd.

645 S. Central Ave. 2400 Belvidere Rd. Michael Reese Hospital 303 E. Superior St. Nurses' Residence, Box 122 427 West Dickens Ave. St. Anthony dePadua Hospital Chicago 23 411 W. Dickens St.

Michael Reese Hospital Decatur & Macon Co. Hosp. 7438 Adams St. 1431 N. Claremont Ave. 4456 N. Monticello Ave. U. S. Marine Hospital **Hotel Carlton** 1517 S. Michigan Ave. St. Francis Hospital 518 N. Austin Blvd. 939 N. LaSalle St.

Jackson Park Hospital Garfield Park Hospital 616 N. 12th Ravenswood Hospital 1931 Wilson Ave. South Shore Hospital

St. Mary's Hospital

Sherman Hospital Norwegian American Hospital Chicago 22 422 Prospect Norwegian American Hospital Chicago 22

6915 S. Winchester St. 201 E. Delaware Pl. 112 West 109th St.

Chicago 25 Chicago 21

Oak Park Chicago 47 Chicago 37

Chicago 14

Chicago 7

Chicago 13 Chicago 18 Oak Park Waukegan Chicago 11 Chicago 13 Overseas

Chicago 51 Chicago 45 Scott Field

Joliet Chicago 20 E. Greenwich, R. I.

Chicago 44 Waukegan Chicago Chicago 11 Chicago 14

Chicago 14 Overseas Chicago Decatur 10 Forest Park Chicago 22 Chicago 25 Chicago 13 Chicago 5

Evanston Oak Park Chicago 10 Galesburg Chicago 49 Chicago Melrose Park Chicago 40

Oak Park Chicago Elgin Alton

Chicago 36 Chicago 11 Chicago 28

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Neeley, 2nd Lt. Dorothy M. England General Hospital

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645 S. Central Ave. Percy Jones Hospital

1142 W. Lawrence Ave. 256 E. Market Square 6 Tuscan Court 189 Avon Rd. 1051 Madison St. 518 N. Austin Blvd. 5001 N. Broadway Sherman Hospital 4608 N. Beacon St. 1928 Highland Ave. St. Joseph's Hospital Ravenswood Hospital 1917 W. Wilson Ave. 1036 N. 22nd St. 1323 Websford Ave. 2358 E. 70th Place, Apt. 406 931 Oakdale Ave. Swedish Covenant Hospital 1101 State St. 824 W. Aldine St. 1667 N. Richmond St. 2926 Lake Park Ave. 1211 N. LaSalle St. St. John's Hospital

R.R. No. 4 **Edgewater Hospital**

Illinois Central Hospital St. An's Hospital 525 W. Arlington Pl. 109 West Oak St. 5145 N. California Ave. St. Luke's Hospital Ravenswood Hospital

Chicago 37 Chicago 18 Chicago 24 Chicago 14 Oak Park Chicago 24 Chicago 51 Springfield Chicago 5 Oak Park Chicago 5 Alton DuQuoin Chicago 44 Chicago 14 Oak Park Kankakee Chicago 40 Alton Decatur **Great Lakes** Chicago 44 Battle Creek, Mich. Springfield Lake Forest Urbana Elmhurst Oak Park Oak Park Chicago 40 Elgin Chicago 40 Wilmette Chicago 14 Chicago 40

Milwaukee, Wis. Des Plaines Chicago 49 Chicago 14 Chicago Pekin Chicago 13 Chicago 47 Chicago 16 Overseas Chicago 10 Springfield Robinson **Overseas** Chicago 26 Harvey Atlantic City, N. J. Chicago 37 Oak Park Chicago 51 Chicago 14 Chicago 10 Chicago Chicago 5 Chicago 40

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432 N. Ashland 303 E. Superior St. 536 Webster Ave. St. Margaret's Hospital

San Nicolas 709 6400 Normal Blvd.

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Ingalls Memorial Hospital Decatur & Macon Co. Hospital Decatur 10 Station Hospital

536 Webster Ave. Alton Memorial Hospital 302 Union St. Illinois Central Hospital Deaconess Hospital 303 E. Superior St. Mercy Hospital Copley Hospital

6644 S. Yale Ave., Apt. G3 2632 Winona Ave. Victory Memorial Hospital

St. Elizabeth's Hospital 5733 N. Francisco Ave. St. Elizabeth's Hospital 1245 N. LaVergne Ave. 244 E. Pearson St. Springfield Memorial Hospital Springfield 143 S. Ninth Ave. Michael Reese Hospital 814 E. Lake Ave. 715 Cornelia Ave. 218 Randolph St. 195 E. Chestnut St. Children's Memorial Hospital 3249 S. Oak Park Ave. St. Elizabeth's Hospital St. Clara's Hospital St. Mary's Hospital St. Joseph's Hospital St. Vincent's Hospital 1120 N. Leavitt St. St. John's Sanitarium St. Mary's Hospital RFD No. 3 St. Francis Hospital St. Vincent's Hospital St. Joseph's Hospital

LaGrange Chicago 11 Chicago 14 Spring Valley Overseas Havana, Cuba Chicago 21 Blue Island **Overseas** Oak Park Chicago 21

Chicago 16

Alton Chicago 29 Oak Park Woodstock Belleville Treasure Island San Francisco Overseas Harvey Camp McCoy, Wis. Chicago 14 Alton **Joliet** Chicago 37 Lincoln Chicago 11 Chicago 16 Aurora Overseas Chicago 21 Chicago Waukegan Overseas Chicago 22 Chicago 45 Chicago 22 Chicago 51 Chicago 11 Maywood Chicago Ladysmith, Wis. Chicago 13 Peoria 5 Chicago 11 Chicago 14 Berwyn Belleville Lincoln Decatur 1 Highland Taylorville Chicago 22 Springfield Streator **Nokomis** Litchfield Taylorville Highland

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Methodist Hospital 635 S. Johnson St. 2636 Winona Ave. 4155 S. Drexel Ave. 1433 N. Claremont Ave. 659 Wrightwood Ave.

8645 Vernon Ave. Station Hospital 6736 Dorchester Ave. 631 N. Dunton Ave. 250 E. Superior St. Copley Hospital Alexandria Hotel Rush & Ohio St. St. Francis Hospital 2926 Lake Park Ave. 2666 East 77th St. 7121 Stanley Ave.

Evanston Hospital Englewood Hospital Mercy Hospital Evanston Hospital

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7 Wildwood Road Marion General Hospital 1047 Northwood Blvd. Quarters 1012 Billings General Hospital Station Hospital St. Catherine's Hospital 2902 Fairfield Ave. 110 N. Cherry St.

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Watts, Edith

515 High Ave. E. 1815 — 6th Ave. 212-214 Tucker Bldg. University Hospital St. Joseph Mercy Hospital

Jennie Edmundson Memorial Hospital Mercy Hospital 112½ W. Washington St. 1909 Jackson St.

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c/o Mrs. W. I. Watts

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Bethel Deaconess Hospital St. Rose Hospital S.B.A. Hospital Community Hospital St. Francis Hospital

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Riverside Hospital 233 Henry Clay Blvd. 641 Park Ave.

St. Joseph's Hospital

1110 Francis Bldg.

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218 N. Salcedo St. 1904 Tulane Ave. 6414 Panola St.

3554 Lillian St. 4629 Palmyra St. 415 Codifer Ave. Conway Memorial Hospital P. O. Box 1941 Route No. 1, Box 260 8127 Spruce St. 8127 Spruce St. 1702 Jackson St. **Baptist Hospital** 907 Cameron St. 336 N. St. Patrick St. 1330 Louisiana Ave. Charity Hospital Station Hospital

V.W.B. Clinic Box 447 519 May St 225 Orion Blvd. 1413 Hillary 2220 Constance St. 5534 Prytania St. Highland Sanitarium Baptist Hospital, Box 1872 Charity Hospital Haynesville Hospital 1200 Fairfield Ave. 3518 Piedmont Drive No. Louisiana Sanitarium 3020 St. Claude Ave. 1416 Fifth St. 619 Chartres St. 3020 St. Claude Ave. Box 12, Route 1 Minden Sanitarium 508 St. Peters St. 4171 Canal St. 4417 Cleveland Ave.

LaGarde Hospital

Bastrop General Hospital

Camp Polk, La. New Orleans 13 **New Orleans 13** New Orleans 18

17.

Sulphur New Orleans 19 **New Orleans** New Orleans 18 Franklin

Shreveport 65 New Orleans Metaria 20 Monroe Alexandria

Alexandria New Orleans 18 **New Orleans 18** · Monroe

Alexandria Lafayette New Orleans 19 **New Orleans 15** New Orleans 13 Camp Livings-

ton Monroe Ruston **Jennings**

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New Orleans 17 Shreveport **New Orleans** Alexandria New Orleans 12 **New Orleans** White Castle Minden

New Orleans 16 New Orleans 19 **New Orleans** Bastrop

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Shreveport New Orleans 13 New Orleans 13 Fort Sam Houston, Tex. Shreveport New Orleans 13 New Orleans 20

Womack, Mrs. John Wesley 1448 Woodrow St. Word, Mattie T. 1410 St. Andrew S Ziegler, Mrs. Sara P.

1410 St. Andrew St. 514 Arlington Dr.

65 Sherman St.

Mercy Hospital

Mercy Hospital

31 Spruce St.

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800 N. Washington St. Sinai Hospital Johns Hopkins Hospital Peninsula General Hospital

Maine General Hospital

1032 Boucher Ave. c/o Mrs. Mary Schreiner 5000 Cordelia Ave.

415 Louisiana Ave. 620 W. Lombard 2702 E. West Highway P. O. Box 166 6515 Frederick Road Mercy Hospital St. Joseph's Hospital General Hospital

3931 Ridgewood Ave. 1206 N. Calvert St.

1614 W. Baltimore St.

St. Agnes Hospital

4823 Reisterstown Road 1222 N. Patterson Ave. Johns Hopkins Hospital 101 W. Monument St. c/o Mrs. L. Seniff, 1036 Mathews Ave. 800 N. Washington St. 1400 N. Caroline St. 308 Central Ave. 308 Central Ave. 508 N. Broadway

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Overseas Annapolis 5

Baltimore 15 Overseas Cumberland Baltimore 1 Chevy Chase Centreville Baltimore 78 Baltimore 2 Baltimore 13 Camp Pickett, Va. Baltimore 15 Baltimore 2

Baltimore 29

Baltimore 23 Baltimore 15 Baltimore 13 Baltimore 5 Baltimore Utica, N. Y.

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Berkshire School 316 Beal St. 14 Pierrepont Road

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31 S. Russell St. St. Vincent's Hospital Lynn Hospital 7 High St. 170 Grove St. 39 Moody St.

Main St. Salem Hospital 48 Banks St. 37 Burncoat Terrace 10 Bennett St. 73 Vernon St. 233 Carew St. Providence Hospital St. Luke's Hospital St. Vincent Hospital Mercy Hospital Mercy Hospital Farren Memorial Hospital Providence Hospital St. Luke's Hospital Mercy Hospital Sr. M. Lawrence Justinian Providence Hospital Mercy Hospital

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Worcester 5 Pittsfield Webster Whitinsville Malden 48 Waltham 54 Pittsfield Uxbridge Boston 15 North Adams Boston 14 Overseas Boston 14 Oklahoma City, Okla. Sheffield Wollaston 70 Newton Lower Falls

Overseas **Overseas** Boston 15 Boston 14 Brookline 46 Brookline 46 Boston 15 Quincy 69 Salem New Bedford Camp Fannin, Tex. Boston 14 Worcester 5 Lynn Whitinsville Melrose 76 Chestnut Hills 67 Lenox

Salem **Brockton 18** Worcester 5 Beverly Worcester 4 Springfield Holyoke Pittsfield Worcester 4 Springfield 4 Springfield 4 Montague City Holyoke Pittsfield Springfield 4 Holyoke Springfield

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Myers
Teitsch, Christine F.
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St. Mary's Hospit
741 W. Euclid
1003 Rademacher
University Hospit
Naval Dispensary

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831 West Six Mile I
Eloise Hospital
19338 Braile
U. S. Marine Hospita
2081 W. Euclid
76 Newberry St.
1527 S. Warren
435 Wildwood Ave
22915 Beach St.
22915 Beach St.
21 Goddard St.
16234 Cruse Ave.
6841 St. Johns

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1298 Fourth St. 235 E. Alexanderine St. Station Hospital, U.S.M.A.

St. Joseph's Hospital 633 N. East St. USNR Naval Hospital

1121 Burr St.

Pensacola, Fla. Battle Creek

Ann Arbor Detroit Detroit 26 Detroit 2 Detroit 9 Ann Arbor **Overseas Overseas** Gulfport, Miss. St. Johns Detroit 3 Eloise Detroit 19 Detroit 15 Detroit 6 Pontiac 18 Saginaw Jackson Dearborn Detroit 12 Webster, Mass. Detroit 27 Detroit 10 **Grand Rapids 5** Detroit 13 Jackson West Dearborn **East Detroit** Washington 19, D. C Muskegon Detroit 1 West Point.

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3740 John R St. 52 Murphy Ave. 1001 Begole 1021 LaSalle 2903 S. Jefferson Ave. 2331 Van Alstyne Blvd. 1225 Lake Drive, S.E. 3005 W. Chicago Blvd. 3740 John R St. c/o Dr. G. E. Myers

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Detroit 1 Pontiac 18 Flint Pontiac Saginaw Wyandotte Grand Rapids Detroit 6 Detroit Shawnee, Ohio Owosso Ann Arbor Detroit 6 Calif.

Saginaw Detroit 14 Detroit 1 Flint Detroit 12 Grand Rapids Overseas Detroit 2 Long Beach 4. Ann Arbor Grand Rapids 5 Flint 2 Detroit 2 Detroit 1 Detroit 8 Detroit 6 Detroit 7 Ann Arbor Detroit 8 Detroit 6 Ypsilanti Fremont Flint 2 Detroit 1 Detroit 1 Houghton Detroit 4 Detroit 1 Marquette Detroit 17 Detroit 11 Grosse Pointe Detroit Ironwood Detroit 2 Detroit 1 Detroit 26 Petoskey Detroit Flint 2 Muskegon **Jackson** Battle Creek Highland Park Bay City Ludington Detroit 5 Detroit 8

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12101 Laing 18445 Lancashire Road Mercy Hospital 18485 Prevost 426 S. Church St. Harper Hospital Leila Y. Post Montgomery Hos. Battle Creek

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Ypsilanti Grand Rapids 3 McBain Petoskey Detroit 1 Overseas Lake Orion Berkley Bay City Detroit 13 Saginaw Detroit 2 Hudson Detroit 12 Detroit 2 Grosse Pointe 30 Detroit 21 Newberry Lansing Overseas Detroit 24 Detroit 23 Benton Harbor Detroit 19 Hudson Detroit 1 Metamora Detroit Detroit 14 Saginaw 21 Detroit 1 Portsmouth, Va. Grand Rapids Berkley Saginaw Midland Pontiac 18 **Grand Rapids** Detroit 1 Kalamazoo Ypsilanti Detroit 13 Detroit 1 Detroit 4 Detroit 6 Benton Harbor Detroit 21 Detroit 21 Menominee Manistee Detroit Mt. Clemens Kalamazoo **Grand Rapids** Escanaba Marquette Detroit 21 Grand Rapids **Grand Rapids** Mt. Clemens Detroit 26

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337 Judson St.

2440 Grand Ave. 369 Glendale Providence Hospital 1025 Randolph St. 2800 W. Grand Blvd. 5145 Harold St. 14912 Promenade 3270 Sophia St. Percy Jones Hospital Williams, Lt.(jg) Ernestine U. S. Naval Hospital McIntire Unit Mt. Carmel Mercy Hospital 3304 Burlingame Route No. 2

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Minneapolis 4 St. Paul 6 St. Paul 2 Pipestone Minneapolis 7 Minneapolis 9 Ovearseas Oakland, Cal. 14 Minneapolis 4 Des Moines, Ia. Anoka Aitkin Duluth 5 St. Paul 2 Duluth Fairmont Minneapolis 4 Austin Montevideo Winona Rochester

Pontiac 2

Fort Riley, Kan. Minneapolis 7 Minneapolis 7 Duluth 5 Minneapolis 14 St. Paul 4 St. Paul 2 Overseas

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Rochester Minneapolis Farragut, Idaho Overseas Minneapolis 4 Minneapolis 4 St: Paul 2 Minneapolis Minneapolis Fergus Falls St. Paul Minneapolis 4 St. Paul 4 Minneapolis New Ulm Minneapolis 4 Seattle, Wash. Minneapolis 4 Faribault Minneapolis 6 Wabasha Moorhead Alexandria Little Falls Minneapolis Breckenridge Crookston Minneapolis 6 St. Paul 2 St. Cloud Minneapolis 4 Minneapolis Duluth Minneapolis

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1310 Admiral Blvd. Walter Reed Hospital

2319 S. Compton Regional Hospital

Missouri Baptist Hospital 3211 Central St.

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Columbia St. Louis St. Louis 5 Springfield St. Louis 8 Lexington St. Louis 10 St. Charles St. Louis 13 St. Louis 8 Overland St. Louis 12 St. Joseph 16 St. Louis 10 Newport, N. Car. St. Louis 12 Koch St. Louis 9 St. Louis 10 Overseas Kansas City 6 Washington, D. C. St. Louis 4 Camp Shelby, Miss. St. Louis 8 Kansas City 2 Overseas St. Louis 10

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Clinton, Iowa Lincoln Omaha 8 Lincoln 2 Omaha 11 Scottsbluff Overseas N. Car. Omaha 5 Omaha Omaha 5 Lincoln.2 Omaha 2

North Platte

Fremont

Omaha 7

Lexington

Columbus Sidney Lincoln Howells Omaha 11 Omaha 11 Fort Lewis, Wash. Hastings Lincoln 2 Norfolk Lincoln 6 Beatrice Omaha 3 Omaha 11 Osmond Lincoln 2 Alliance Osceola Omaha 8 Omaha 8 Kearney Spalding Omaha 3

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Newark Memorial Hospital 345 Liberty Rd.

929 Revere Ave. 254 Morse St. **Newton Memorial Hospital** Elizabeth General Hospital 276 Bay Ave. 14 S. Clarke Ave. Naval Hospital Dover General Hospital Hospital of St. Barnabas 6902 Browning Rd. 201 Lyons Ave. Morristown Memorial Hospital Morristown 270 Montclair Ave. Monmouth Memorial Hospital St. Vincent's Hospital Presbyterian Hospital 321 S. Third St., Apt. 2 St. Michael's Hospital Newark City Hospital St. Barnabas Hospital Dr. E. C. Hazard Hospital All Saints' Hospital Newark Memorial Hospital Memorial Hospital 10 N. Ridgewood Rd. Elizabeth General Hospital Atlantic City Hospital 370 Central Ave., Apt. D-3 Middlesex General Hospital Cooper Hospital Presbyterian Hospital 300 Carteret Place Presbyterian Hospital St. Michael's Hospital

Newark 7 Plainfield Newark 5 Vineland Newark 2 Newark 8 Newark 7 Bridgeton Highland Park East Orange Hopatcong Trenton 9 East Orange New Brunswick Newark 8 Camden Hilo, Hawaii Trenton Camden Newark 7 Passaic Long Branch Wharton Morristown Overseas Newark 3 Englewood Overseas Trenton 9 Camden Newton Elizabeth Glen Ridge Somerville Bainbridge, Md. Dover Newark 2 Merchantville Newark 8 Newark 4 Long Branch Montclair Newark 7 Hammonton Newark 2 Newark 7 Newark 2 Long Branch Morristown Newark 3 Morristown South Orange Elizabeth Atlantic City Orange New Brunswick Camden Newark 7 Orange Newark 7

Newark 2

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15 Diller Ave. St. Mary's Hospital

Princeton Hospital 11 Pine Ave. 7 Davidson St. St. Mary's Hospital Newark City Hospital St. Peter's General Hospital

Newton Hoboken Overseas Princeton W. Long Branch Clifton Hoboken Newark 7 New Brunswick

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1214 Putnam Ave. 445 Champlain Ave.

20 Park Ave.

68 Whittier St. Wyckoff Heights Hospital Ellis Hospital Knickerbocker Hospital Potsdam General Hospital 41 Bridge St. U. S. Marine Hospital Vassar Hospital 148-18 21st Ave. Morrisania Hospital 2070 Clinton Ave. Morrisania Hospital 129 W. 70th St. U. S. Army Hospital Fort Miles 144-15 Lakewood Ave. 531 E. 72nd St. 279 Henry St. Highland Hospital 44 Cottage St. Ellis Hospital Midwood Hospital Coney Island Hospital Ocean Parkway Lutheran Hospital

157 VanCortland Ave. Long Lake Goldsmith Street New York Hospital Troy Hospital 1845 Becker St.

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> 719 Halcomb St. Chas. Wilson Hospital Roosevelt Hospital Roosevelt Hospital State Institute for the Study of Malignant Diseases Jamaica Hospital Coney Island Hospital Charles Wilson Hospital 25 Central Park West Walter Reed Gen'l Hospital

c/o Mrs. Wildman 276 Wardman Road 310 Winthrop St. Lawrence Hospital Troy Hospital Strong Memorial Hospital 70-01 113th St. 1484 Glenwood Blvd. Strong Memorial Hospital 503 E. 73rd St., Apt 26 Strong Memorial Hospital 25 Pine Ridge Terrace Station B, Hudson River State Poughkeepsie Hospital 1700 Harrison Ave.

Jamaica Hospital Brooklyn Hospital U. S. Public Health Hospital

Israel-Zion Hospital 108 S. Village Ave.

28 Grosvenor Rd., Denecrest

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Roosevelt Hospital 428 W. 59th St.

Woman's Hospital Vassar Brothers Hospital

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New York 19 New York 19

Kenmore Brooklyn 25 Bronxville Troy Rochester 7 Forest Hills Schenectady Rochester 7 New York 21 Rochester 7 Buffalo 11

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177 Lincoln Blvd. 24 Walnut Terrace Nassau Hospital 1255 Delaware Ave.

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Brooklyn 25
Longview, Tex.
Ordnance, Ore.
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Jamaica 2
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St. Catherine's Hospital St. Charles Hospital Mercy Hospital St. Jerome's Hospital Mercy Hospital Mercy Hospital, 565 Abbott Rd. Buffalo 20 Mercy Hospital

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Randolph Hospital Maria Parham Hospital **Rutherford Hospital** Box 1251 Memorial Hospital 2307 Prince St., C-11 Park View Hospital Watts Hospital

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Mercy Hospital St. Joseph's Hospital Trinity Hospital St. John's Hospital Mercy Hospital Mercy Hospital Mercy Hospital St. Michael's Hospital Mercy Hospital Mercy Hospital St. Joseph's Hospital Good Samaritan Hospital Good Samaritan Hospital Deaconess Hospital

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Cleveland Clinic Hospital City Hospital, 41 Arch St. 10615 Lake Ave. 307 Aberdeen Dr. 160 Terrace Ave.

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University Hospitals

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3931 Riverside Drive 1701 W. 28th St. 2453 Clybourn Pl. City Hospital 1812 E. 105th St Romito, Mrs. Florence Bldg. 11, N.A.T.T.C. 389 Pearl St. 241 8th St., NW 2230 Victoria Ave. 1124 Covington St. 1124 Covington St. 4311 Prospect Ave. St. Elizabeth's Hospital University Hospital Good Samaritan Hospital St. Alexis Hospital Mercy Hospital Mercy Hospital Good Samaritan Hospital 702 Cleveland Ave., N.W. Wakeman General Hospital

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Cleveland 6 Dayton 6

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Cleveland 13 Glenmont Columbus 5 Mariemont Overseas Overseas Dayton 5 Cleveland 8 Cincinnati 19 Cleveland 9 Cleveland 6 Norman, Okla. Long Beach, Cal Akron Barberton Dayton 6 Youngstown 4 Youngstown 4 Cleveland 3 Dayton Columbus Cincinnati 20 Cleveland 4 Hamilton Toledo 2 Cincinnati 20 Canton Camp Atterbury, Ind. Youngstown 1 Cleveland 4 Akron 7 Cleveland 9 Hamilton Cleveland 15

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67 B. Elizabeth Road 2663 Union Ave. 1030 18th Ave., S. 225 Island Home Blvd. Regional Hospital

Naval Air Station Naval Dispensary, Box 41 1515 Waverly Road Margarita Hospital

1301 Eastmoreland St. Thomas Hospital c/o Mrs. Ada Herr, 2683 Lowell Memphis

1273 Eastmoreland 48 S. Diana St Box 388, Oak Ridge Hospital 615 N. Willett St. 654 Stonewall Place St. Joseph's Hospital 1914 Grand Ave. Oak Ridge Hospital Hillcrest Drive Apt. 33, Ft. Sanders Manor

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